VOLUME PROVIDERS OF MEDICAL EXAMINATIONS FOR THE SOCIAL SECURITY DISABILITY PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

AND

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

SEPTEMBER 18, 1981

Serial 97-27

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
86-272 O WASHINGTON : 1981

H781-4

COMMITTEE ON WAYS AND MEANS

DAN ROSTENKOWSKI, Illinois, *Chairman*

SAM M. GIBBONS, Florida
J. J. PICKLE, Texas
CHARLES B. RANGEL, New York
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, Jr., Indiana
HAROLD FORD, Tennessee
KEN HOLLAND, South Carolina
WILLIAM M. BRODHEAD, Michigan
ED JENKINS, Georgia
RICHARD A. GEPHARDT, Missouri
THOMAS J. DOWNEY, New York
CECIL (CEC) HEFTEL, Hawaii
WYCHE FOWLER, Jr., Georgia
FRANK J. GUARINI, New Jersey
JAMES M. SHANNON, Massachusetts
MARTY RUSSO, Illinois
DON J. PEASE, Ohio
KENT HANCE, Texas
ROBERT T. MATSUI, California
DON BAILEY, Pennsylvania

BARBER B. CONABLE, Jr., New York
JOHN J. DUNCAN, Tennessee
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
RICHARD T. SCHULZE, Pennsylvania
BILL GRADISON, Ohio
JOHN H. ROUSSELOT, California
W. HENSON MOORE, Louisiana

John J. Salmon, *Chief Counsel*
Joseph K. Dowley, *Assistant Chief Counsel*
Robert J. Leonard, *Chief Tax Counsel*
A. L. Singleton, *Minority Chief of Staff*

Subcommittee on Social Security

J. J. PICKLE, Texas, *Chairman*

ANDY JACOBS, Jr., Indiana
RICHARD A. GEPHARDT, Missouri
FRANK J. GUARINI, New Jersey
JAMES M. SHANNON, Massachusetts
DON BAILEY, Pennsylvania

BILL ARCHER, Texas
BILL GRADISON, Ohio
JOHN H. ROUSSELOT, California
PHILIP M. CRANE, Illinois

James W. Kelley, *Professional Staff*
Frederick B. Arner, *Professional Staff*
Janice M. Gregory, *Professional Staff*

Subcommittee on Oversight

CHARLES B. RANGEL, New York, *Chairman*

SAM M. GIBBONS, Florida
J. J. PICKLE, Texas
HAROLD FORD, Tennessee
CECIL (CEC) HEFTEL, Hawaii
WILLIAM M. BRODHEAD, Michigan
WYCHE FOWLER, Jr., Georgia

PHILIP M. CRANE, Illinois
W. HENSON MOORE, Louisiana
JOHN J. DUNCAN, Tennessee
JAMES G. MARTIN, North Carolina

CONTENTS

Page

Press releases announcing hearing 1

Witnesses:

- Social Security Administration, Sandy Crank, Associate Commissioner for Operational Policy and Procedures; Fred Schutzman, Associate Commissioner for Assessment; and Rhoda Greenberg, Director, Office of Disability Programs 4
- Pennsylvania Department of Labor and Industry, George Lowe, director, Bureau of Vocational Rehabilitation, and John DelPaine, assistant director, Disability Determination Division 67
- Tennessee Disability Determination Section, Herbert L. Brown, director 71

VOLUME PROVIDERS OF MEDICAL EXAMINATIONS FOR THE SOCIAL SECURITY DISABILITY PROGRAM

FRIDAY, SEPTEMBER 18, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Subcommittee on Oversight,
Washington, D.C.

The subcommittees met at 10 a.m., pursuant to notice, in room 1100, Longworth House ,Office Building, Hon. J. J. Pickle (chairman of the Subcommittee on Social Security) presiding.

[Press releases announcing the hearing follow:]

[Press release of Aug. 21, 1981]

Hon. J. J. Pickle and Hon. Charles B. Rangel, Chairmen of the Ways and Means Subcommittees on Social Security and Oversight, Respectively, Announce Joint Hearings on Possible Irregularities in Medical Examinations Purchased From Volume Providers for the Social Security Disability Program

Honorable J. J. Pickle, (D-Texas), Chairman of the Subcommittee on Social Security, and Honorable Charles B. Rangel, (D-N.Y.), Chairman of the Subcommittee on Oversight, Committee on Ways and Means, announced today that their Subcommittees would hold a joint hearing on the procedures which cover the purchase of independent medical exams. These hearings will begin on Friday, September 11 at 10:00 a.m. in Room 1100, Longworth House Office Building. Medical examinations play a crucial role in determining an individual's eligibility for social security and SSI disability benefits and their quality and timeliness go to the heart of both the fairness and the solvency of the programs.

In its hearing the Subcommittees intend to invite the Commissioner of Social Security and directors of some State agencies to assess the nature of the problem of "volume" providers and to ascertain the role and responsibility of Federal and State governments, respectively, in supervising these providers of medical examinations. Other hearings will follow if they are found necessary.

[Press release of Sept. 9, 1981]

Hon. J. J. Pickle and Hon. Charles B. Rangel, Chairmen of the Ways and Means Subcommittees on Social Security and Oversight, Respectively, Announce Postponement of Hearings Originally Scheduled for Friday, September 11, 1981, on Possible Irregularities in Medical Examinations Purchased From Volume Providers for the Social Security Disability Program

Due to the funeral services being held for the Honorable William R. Cotter, the joint hearings scheduled to be held by the Subcommittees on Social Security and Oversight of the Committee on Ways and Means on Friday, September 11, 1981 have been postponed until Friday, September 18, 1981.

The hearings will deal with the procedures covering the purchase of independent medical examinations which play a crucial role in determining an individual's eligibility for social security and SSI disability benefits under the Social Security Act.

These hearings will begin at 10:00 a.m. Friday morning, September 18, in Room H-137 of the Capitol. The Commissioner of Social Security and directors of some state agencies have been invited to assess the nature of the problem of "volume providers" and to ascertain the role and responsibility of federal and state governments, respectively.

Mr. PICKLE. The subcommittee will come to order. The Chair regrets that he was a few minutes late, but he and Mr. Rangel both had to go to the floor for just a few minutes.

Today we are dealing with one of the most important elements of the disability insurance program. Adequate medical evidence appears to be one of the keys to controlling the costs of the program. With increasing emphasis on medical documentation, the disability incidence rate has declined markedly in recent years. Our subcommittee has emphasized the necessity of purchasing independent medical evidence and has supported adequate appropriations for this purpose. The hearing today deals with allegations that there are abuses in some elements of the system.

Certain organizations which specialize in providing disability examinations are being questioned as to whether their product enables the State agencies and the ALJ's to make decisions which reflect accurately and completely the claimants' medical impairment. We do not prejudge the issues. You will hear in these upcoming hearings support and criticism of these providers. We intend to get a better understanding of the operation of the "volume providers" and determine whether they are being properly supervised by the State agencies and the Social Security Administration. This a sensitive and difficult area to deal with, but it is too important to ignore.

Today we will hear from the Social Security Administration and the State agencies of Pennsylvania and Tennessee. In future hearings, we intend to hear from some of the people who allege that there are irregularities.

Before we recognize the first witness, the Chair would be pleased to yield to the gentleman from Pennsylvania, Mr. Bailey, for a preliminary statement.

Mr. Bailey.

Mr. BAILEY. Thank you, Mr. Chairman.

I think we are at a point right now, Mr. Chairman, where obviously there are some very serious questions to be raised. I hesitate to point a finger in any particular direction, but it appears to me at least at this stage that the Social Security Administration, in terms of evaluating information about volume providers, their role and function, supervising them and perhaps relaying that information to the respective State agencies involved, might have been—and we don't know yet—might have been somewhat remiss.

At this point, I ought to throw a compliment, I suppose, in the direction of a local channel 11 news reporter, a fellow that did some investigatory work—Bill Moushey, who I think ought to be commended for cooperation with the staff in raising questions about some of the practices of volume providers in Pittsburgh.

Hopefully the hearings will act as a spur to begin the raising and asking of questions, to get something done with it—specifically, some apparent connections at least between volume providers and practices that perhaps may not have been proper in Tennessee involving cases there. I think we ought to recognize the fact that, although we don't know exactly what the outcome of these hearings will be, that there are some very serious questions raised, and that these hearings hopefully will act as a spur to further investigation to get these problems cleared up, if indeed they exist.

Thank you, Mr. Chairman.

Mr. **Pickle**. Now the Chair will recognize the chairman of the Oversight Subcommittee of this committee, the Hon. Charles Rangel.

Mr. **Rangel**. We would like to take a closer look at how consultative medical examinations are being handled in the social security disability program. In particular, we want to determine whether there has been improprieties of a financial, ethical, or professional nature on the part of any of the professional groups, all the volume providers, that is, in the performance of examinations or preparations of medical reports.

We are concerned about the questions of the validity of the examinations being performed and the reliability of reports that are filed. We want to know whether a physician can reasonably be expected to perform the volume of examinations that they have been burdened with and still meet professional standards of quality and comprehensiveness.

Do we have assembly line medical examinations? Is there any justification for the use of mass produced word processing generated medical reports that physicians sign even though they have never had the opportunity to even see the patient?

We are concerned about the adequacy of the supervision and monitoring of the responsibilities by the State disability agencies and the Social Security Administration. It does not greatly enhance our confidence to find that SSA had to be jolted by a district court judge and a U.S. attorney ordering an FBI investigation, to devote some attention to the issue.

We don't believe that we can say let the local and State governments do the job. We believe on this committee we have the responsibility. It is a Federal program and requires oversight by our committee and that is the reason why we are chairing this meeting. Are we paying close enough attention? Is there support that the Congress should be giving to you that we are not giving? Are there areas that we should concern ourselves with that we have not provided the support and direction in order to provide the answers to the questions the citizens are asking and Members of Congress are asking, and our committee? This is the main reason why we are having these hearings.

I thank the chairman, Mr. Pickle, for affording our committee the opportunity to have this joint hearing, so that you would know that this record is for the full committee, even though the chairman of social security and my committee on oversight will be sharing the joint record. It saves you time really, so you don't have to come up here twice.

Mr. **Pickle**. Thank you, sir.

I would want to emphasize that this is a joint hearing and we will continue to go forward in the weeks ahead. This is just one of a series of hearings we will have on the subject.

The first witness this morning will be a representative from the Social Security Administration, Mr. Sandy Crank. Mr. Crank is the Associate Commissioner for Operational Policy and Procedures. Also, I want to recognize at the table Mr. Fred Schutzman, Associate Commissioner for Assessment; and Ms. Rhoda Greenberg, Director, Office of Disability Programs. We are glad to have all three of you here.

Now, Mr. Crank, if you will proceed with your statement.

STATEMENT OF SANDY CRANK, ASSOCIATE COMMISSIONER FOR OPERATIONAL POLICY AND PROCEDURES, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY FRED SCHUTZMAN, ASSOCIATE COMMISSIONER FOR ASSESSMENT; AND RHODA GREENBERG, DIRECTOR, OFFICE OF DISABILITY PROGRAMS

Mr. **Crank**. Thank you, Chairman Pickle and Chairman Rangel. I am pleased to be here to discuss with your subcommittees the role of consultative medical examinations in the social security disability determination process and the use of so-called "volume sources" for such examinations. I share the subcommittee's belief that the consultative examination is a critical part of the disability determination process and that social security is responsible for assuring comprehensive direction, coordination and management to State agencies in this area.

Before discussing the specific issues you have been inquiring about, I would like to briefly review the role of the consultative examination in the disability determination process.

As you know, disability for social security and SSI purposes is defined in the statute as inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

I wish to emphasize the words "medically determinable" because I believe they reflect a clear congressional intent that decisions as to whether a person is or is not disabled are to be based on more than applicant allegations, physician opinion about ability to work, or diagnoses alone. Our medical development policies carry out that congressional intent by requiring decisions to be based on medical evidence from treating and other sources which includes objective results of examinations and other medical tests that establish diagnoses, limitations on work related activities, and prognoses.

Determinations of disability must be made for new applicants and for people already entitled to disability benefits whose impairments are not expected to be permanently disabling. Nearly 2.9 million determinations of this kind will be required for fiscal year 1982. This means that a tremendous amount of medical evidence is and will continue to be required from the medical community. The preferred source for this evidence is the physician or clinic treating the claimant. We anticipate that about 60 percent of these determinations will be made based on the medical evidence supplied by the claimant's treating physician or clinic.

In about 40 percent of the cases, it will be necessary to acquire independent medical evidence at Government expense for one or more of the following reasons:

First, the evidence from the treating sources does not contain all needed information and cannot be readily supplemented;

Second, there are conflicts in the evidence which must be resolved; or

Third, in the case of supplemental security income applicants, there is no current treatment source and the claimant is unable to pay for a current examination.

As you have noted, we are projecting a decrease in the percent of claims that can be determined on the basis of evidence supplied by the treating sources and a corresponding increase in the claims requiring consultative examinations. More specifically, we are projecting that there will be an increase in the overall examination rate from 30 to 40 percent. This is attributable to the increase in the number of continuing disability investigations which will be done as a result of the periodic review requirement and the 75-percent consultative examination rate expected in those cases.

Let me turn now to the consultative medical examination itself. As you can see, these examinations play a vital role in the disability determination process.

The Social Security Administration has published regulations and administrative guidelines that set out State disability determination services' responsibilities in obtaining both existing medical evidence and consultative medical examinations. Each State agency, under our Federal-State relationship, is responsible for recruiting and maintaining a network of medical sources that can be used to perform consultative examinations. Each State is responsible for informing its medical community of the requirements of the disability program and how to participate in providing consultative examinations.

Each State is also directed to determine that the payment rates will be for providing medical reports and consultative services. These rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar types of services. In most States, the rates are based on the parent vocational rehabilitation agency or other existing State fee schedules.

Finally, each State agency has the responsibility for reviewing the reports of consultative examinations to assure that all the services purchased have been provided and that the report is complete.

In most States, the network of medical sources used to perform consultative examinations includes individual physicians, group practices, clinics, laboratories, and hospitals. In some States, certain individual physicians, clinics, and group practices meet a substantial portion of the State's consultative examination needs. In some instances, certain medical sources fulfill consultative examination needs in more than one State. The number of consultant sources available for use within a single State ranges from a low of 41 to a high of several hundred.

The State's objective in establishing a network of medical sources of consultative examinations is to secure a full range of medical specialists in sufficient numbers to enable them to arrange apointments and receive reports within reasonable time frames. In many States there are serious shortages of medical specialists. Such shortages exist in many rural areas, and they also exist within certain medical specialties. Some medical sources are unable or unwilling to provide timely appointments or reports and some are unwilling to provide services for the fees States can pay.

In response to these problems, some State agencies have made arrangements with so-called volume providers who are willing to dedicate a portion of their practice or set up needed facilities to do the consultative examinations. In some situations, a "volume source" is a physician in private practice who will block out a day or several hours a week for the State. In others, the volume provider is a clinic type of arrangement.

We support State DDS efforts in developing sources that can provide quality evidence on a timely basis. We consider obtaining reliable medical evidence as quickly as possible a primary requisite to serving people awaiting decisions on their claims. We have set out no separate standards for arrangements with volume sources. However, the same quality, equal and courteous treatment of claimants, timeliness of services, and adequacy of services and reporting, are expected of all sources of consultative examinations, including volume sources.

Once in a while someone challenges the practices of a consultative examination source. Generally, the State DDS is able to quickly resolve the problem by contact with the source. We believe this might have been possible in the now highly publicized case of Suburban Internal Medicine Group.

In that situation, the plaintiffs in seven disability cases and the Office of Hearings and Appeals jointly requested the U.S. District Court for the Western District of Virginia to remand the seven cases to the Appeals Council for further consideration. However, when the court granted this request and remanded the cases of July 8, 1981, the remand order included a statement that the consultative examinations performed by a Dr. Martin for the Suburban Internal Medicine Group were fraudulent.

The court's finding was publicized by several newspapers in the region. The U.S. attorney requested an FBI investigation. SSA concluded that, in light of the court's findings and the FBI investigation, it was prudent to suspend use of the Suburban Internal Medicine Group services until we could look into the group's practices and the adequacy of its services.

Our review of the Tennessee-based Suburban Internal Medicine Group, owned by Drs. Stephen and Grafton Thurman, included contacts with seven State agencies that used their services. Our assessment of the practices used by the group, the credentials of its examining physicians, and the professional adequacy of its services and reports, indicated that its services are satisfactory, although certain minor changes in its reporting practices needed to be made.

We found no evidence of fraudulent activity. Specifically, there was no evidence of services not being performed, of services being misrepresented, incorrect billing, or inappropriate business practices. Our medical staff also reviewed a number of the group's medical reports and found them to be sufficiently detailed with respect to the evaluation the State DDS had requested. Therefore, we withdrew our suspension of the Suburban Internal Medicine Group on August 11, 1981.

The issues raised by the Suburban Internal Medicine Group situation caused us to initiate a review of our regulations, administrative guides, and experiences with the consultative examination process. We have concluded on the basis of our assessment to date that SSA guidelines should be clarified.

We have also begun a review of State DDS policies, procedures and experiences with consultative examinations, and volume source practices in general. The State DDS's are now providing us with current information regarding their procedures and experiences. This information, when complete, will enable us to determine whether additional policies and procedures are needed to assure a proper management of this process.

Chairman Pickle asked how we intend to manage this area in the future. Before outlining our plans, let me describe the problems we believe we need to address.

There is the area of State responsibilities for providing comprehensive monitoring of consultative examination sources. While we have had guidelines describing State responsibilities for reviewing reports and billings, we have not specifically required State monitoring of the examination process itself, or of the adequacy of facilities and equipment or other oversight activities.

With regard to information on effectiveness of the States' management of the consultative examination process, we have not had a disciplined process that permits us to obtain continuing information on the effectiveness of the States' management of their consultative examination process.

With respect to quality assessments of the consultative examination services and reporting, we have not had a specific process that directs State or Federal medical reviewers to assess the adequacy of consultative medical examiners' services and reports.

Last, with respect to special oversight of volume sources, the rapid growth of the program produced a need for consultative examinations that has led to dependence on volume sources in some areas. We did not previously address the question of the need for additional special oversight for this group.

With these problems in mind, let me briefly outline the steps SSA is currently taking to strengthen the management of the consultative examination process.

As a first step, we are issuing a program policy statement which clarifies SSA principles and policy as to acceptable medical evidence and consultative examination practices. This program policy statement sets out State responsibilities for maintaining the program's credibility in the use of purchased medical evidence by assuring that consultative examination practices reflect certain essential characteristics. The physicians doing examinations must be competent to perform them. The physicians's professional conduct must be acceptable. The consulting physicians themselves or through their medical partnerships must have no familial or financial relationship to the claimants they examine. They must not be full or part-time employees of the State disability determination service or the Social Security Administration, except for the rare instance where there is no other qualified medical source available.

In such rare instances the examining physicians must disqualify themselves from participation in the final determination. The reports must be comprehensive and reflect the type of content SSA has specified. The reports must be reviewed and signed by the physician who performs the examination.

This program policy statement outlines the major requirements. More detailed guidance is being prepared and will appear in our program operations manual system. The detailed guidance will include statements as to the elements which must appear in an acceptable medical report in the more commonly encountered medical areas such as internal medicine, orthopedics, psychiatry, and neurology.

We will facilitate the ability of State agencies to share information among themselves on procedures that have improved the consultative examination process in some States.

We will continue to investigate techniques the States can use to assure quality examinations and reports. My staff recently visited the American Medical Association. The AMA suggested we look into peer reviews of consultative services through such organizations as the American Society of Internal Medicine, medical foundations, and State medical associations. We are following through on this advice.

We will see to it that our quality assurance process includes an evaluation of the quality of consultative medical reports that will bring to light problem areas as they occur.

Finally, we will continue our study of the need for special oversight of volume sources and the techniques that might be used to accomplish it. We will issue additional guidelines spelling out State responsibilities in this area.

The steps I have outlined here are the ones we have identified as needed at present. We believe there is more to do and will continue to give our close attention in this area.

To summarize, the number of disability claims being processed by the State disability determination services is substantial and with the required periodic continuing disability review, increasing. By fiscal year 1982, we anticipate that 40 percent of all determinations will require consultative examinations. We anticipate total obligations for consultative examinations in fiscal year 1981 will reach approximately $137 million.

This level of expenditure makes it crucial that the consultative medical examination process be handled effectively at all levels. We have provided substantial guidance on State responsibilities through regulations and administrative guidelines. We intend to clarify and expand this direction. We will continue to set the objectives and goals that need to be achieved in the consultative examination area. However, we will continue to allow the States freedom to manage the selection and maintenance of the networks of physicians they use for consultative examinations, and to use their fee schedules and their authorization processes within their agencies.

We will facilitate the exchange of information among State agencies on successful techniques being used at the State level to manage these responsibilities. We will improve our monitoring of the consultative examination process to identify problems and determine the need for possible changes.

The Social Security Disability Amendments of 1980 directed the Secretary to issue, through regulations, performance standards for State agencies to follow in making disability determinations. We are satisfied that we have the necessary flexibility under that legislation to resolve any known problems in this area and consequently, and have no recommendations for any legislative changes.

Chairman Rangel and Chairman Pickle, that concludes my testimony. I will be happy to answer any questions the committee might have.

[The prepared statement follows:]

STATEMENT OF SANDY CRANK, ASSOCIATE COMMISSIONER FOR OPERATIONAL POLICY AND PROCEDURES, SOCIAL SECURITY ADMINISTRATION

TESTIMONY ON THE CONSULTATIVE EXAMINATION PROCESS

Introduction

Chairman Pickle and Chairman Rangel, my name is Sandy Crank, I am the Associate Commissioner for Operational Policy and Procedures. Accompanying me today are Mr. Fred Schutzman, Associate Commissioner for Assessment and Ms. Rhoda Greenberg, Director of the Office of Disability Programs.

I am pleased to be here to discuss with your Subcommittees the role of consultative medical examinations in the Social Security disability determination process and the use of so-called "volume sources" of such examinations. I share the Subcommittees' belief that the consultative examination is a critical part of the disability determination process and that Social Security is responsible for assuring comprehensive direction, coordination and management in this area.

Background

Before discussing the specific issues you have been inquiring about, I would like to briefly review the role of the consultative examination in the disability determination process.

As you know, disability for social security and SSI purposes is defined in the statute as inability to engage in substantial grainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. I wish to emphasize the words "medically determinable" because I believe they reflect a clear Congressional intent that decisions as to whether a person is or is not disabled are to be based on more than applicant allegations, physician opinion about ability to work, or diagnoses alone. Our medical development policies carry out that intent by requiring decisions to be based on medical evidence from treating and other sources which includes objective results of examinations and other medical tests that establish diagnoses, limitations on work-related activities, and prognoses.

Determinations of disability must be made for new applicants and for people already entitled to disability benefits whose impairments are not expected to be permanently disabling. Nearly 2.9 million determinations will be required for fiscal year 1982. This means that a tremendous amount of medical evidence is and will continue to be required from the medical community. The preferred source for this evidence is the physician or clinic treating the claimant. We anticipate that about 60 percent of these determinations will be made based on the medical evidence supplied by the claimant's treating physician or clinic.

In about 40 percent of the cases, it will be necessary to acquire independent medical evidence at government expense for one or more of the following reasons: 1) the evidence from the treating source does not contain all needed information and cannot be readily supplemented, 2) there are conflicts in the evidence which must be resolved or 3) in the case of SSI applicants there is no current treatment source and the claimant is unable to pay for a current examination. As you may have noted, we are projecting a decrease in the percent of claims that can be determined on the basis of evidence supplied by their sources and a corresponding increase in the claims requiring consultative examinations. Specifically, we are projecting that there will be an increase in the overall consultative examination rate from 30 to 40 percent. This is attributable to the increase in the number of continuing disability investigations which will be done as a result of the periodic review requirement and the 75 percent consultative examination rate expected in those cases.

The consultative medical examination

As you can see, consultative medical examinations play a vital role in the disability determination process.

The Social Security Administration has published regulations and administrative guidelines that set out State disability determination services (DDS) responsibilities in obtaining both existing medical evidence and consultative medical examinations. Each State agency, under our Federal-State relationship, is responsible for recruiting and maintaining a network of medical sources that can be used to perform consultative examinations. Each State is responsible for informing its medical community of the requirements of the disability program and how to participate in providing consultative examinations. Each State is also directed to determine what the payment rates will be for providing medical reports and consultative services. These rates may not exceed the highest rate paid by Federal or other agencies in the State for the same or similar types of services. In most States, the rates are based on the parent Vocational Rehabilitation agency or other existing State fee schedules. Finally, each State agency has the responsibility for reviewing the reports of consultative examinations to assure that all the services purchased have been provided and that the report is complete.

In most States, the network of medical sources used to perform consultative examinations includes individual physicians, group practices, clinics, laboratories, and hospitals. In some States certain individual physicians, clinics, and group practices meet a substantial portion of the State's consultative examination needs. In some instances certain medical sources fulfill consultative examination needs in more than one State. The number of consultant sources available for use within a single State ranges from a low of 41 to a high of several hundred.

Volume providers

The States' objective in establishing a network of medical sources for consultative examinations is to secure a full range of medical specialists in sufficient numbers to enable them to arrange appointments and receive reports within reasonable time frames. In many States there are serious shortages of medical specialists. Such shortages exist in many rural areas. Such shortages also exist within certain medical specialties. Some medical sources are unable or unwilling to provide timely appointments or reports and some are unwilling to provide services for the fees States can pay.

In response to these problems, some State agencies have made arrangements with so-called "volume sources" who are willing to dedicate a portion of their practice or set up needed facilities to do the consultative examinations. In some situations a "volume source" is a physician in private practice who will block out a day or several hours a week for the State. In others, the volume provider is a clinic-type of arrangement. We support State DDS efforts in developing sources that can provide quality evidence on a timely basis. We consider obtaining reliable medical evidence as quickly as possible a primary requisite to serving people awaiting decisions on their claims. We have set out no separate standards for arrangements with "volume sources." However, the same quality; equal and courteous treatment of claimants; timeliness of services; and adequacy of services and reporting are expected of all sources of consultative examinations.

Suburban internal medicine group

Once in a while someone challenges the practices of a consultative examination source. Generally, the State DDS is able to quickly resolve the problem by contact with the source. We believe this might have been possible in the now highly publicized case of Suburban Internal Medicine Group.

In that situation, the plaintiffs in seven disability cases and the Office of Hearings and Appeals jointly requested the U.S. District Court for the Western District of Virginia to remand the seven cases to the Appeals Council for further consideration. However, when the court granted this request and remanded the cases on July 8, 1981, the remand order included a statement that the consultative examinations performed by a Dr. Martin for the Suburban Internal Medicine Group were fraudulent. The court's finding was publicized by several newspapers in the region. The U.S. Attorney requested an FBI investigation. SSA concluded that, in light of the court's findings and the FBI investigation, it was prudent to suspend use of the Suburban Internal Medicine Group services until we could look into the group's practices and the adequacy of their services.

Our review of the Tennessee based Suburban Internal Medicine Group (SIMG), owned by Drs. Stephen and Grafton Thurman, included contacts with seven State agencies that used their services. Our assessment of the practices used by the group, the credentials of its examining physicians, and the professional adequacy of its services and reports indicated that its services are satisfactory, although certain minor changes in its reporting practices needed to be made. We found no evidence of fraudulent activity. Specifically, there was no evidence of services not being performed, of services being misrepresented, incorrect billing or inappropriate business practices. Our medical staff also reviewed a number of the group's medical reports and found them to be sufficiently detailed with respect to the evaluation the State DDS had requested. Therefore, we withdrew our suspension of the Suburban Internal Medical Group on August 11.

SSA's management of the consultative examination process

The issue raised by the Suburban Internal Medicine Group situation caused us to initiate a review of SSA regulations, administrative guides and experiences with the consultative examination process. We have concluded on the basis of our assessment that SSA guidelines should be clarified.

We have also begun a review of State DDS policies, procedures and experiences with consultative examinations and volume source practices in general.

The State DDS's are now providing us with current information regarding their procedures and experience. This information, when complete, will enable us to determine whether additional policies and procedures are needed to assure a proper management of this process.

Chairman Pickle asked how we intend to manage this area in the future. Before outlining our plans, let me describe the problems we believe we need to address.

State Responsibilities for Providing Comprehensive Monitoring of Consultative Examination Sources.—While we have had guidelines describing State responsibilities for reviewing reports and billings, we have not specifically required State monitoring of the examination process, the adequacy of facilities and equipment or other oversight activities.

Information on Effectiveness of the States' Management of the Consultative Examination Process.—We have not had a disciplined process that permits us to obtain continuing information on the effectiveness of the States' management of their consultative examination process.

Quality Assessments of the Consultative Examination Services and Reporting.—We have not had a specific process that directs State or Federal medical reviewers to assess the adequacy of consultative medical examiners' services and reports.

Special Oversight of Volume Sources.—The rapid growth of the program produced a need for consultative examinations that has led to dependence on volume sources in some areas. We did not previously address the question of the need for additional special oversight for this group.

With this in mind, let me briefly outline the steps SSA is currently taking to strengthen the management of the consultative examination process.

Guidelines on State Responsibilities.—As a first step, we are issuing a Program Policy Statement which clarifies SSA principles and policy as to acceptable medical evidence and consultative examination practices. It sets out State responsibilities for maintaining the program's credibility in the use of purchased medical evidence by assuring that consultative examination practices reflect certain essential characteristics. The physicians doing examinations must be competent to perform them. The physician's professional conduct must be acceptable. The consulting physicians themselves or through their medical partnerships must have no familial or financial relationship to the claimants they examine. They must not be full or part-time employees of the State Disability Determination Service or the Social Security Administration, except for the rare instance where there is no other qualified medical source available. In this case they must disqualify themselves from participation in the final determination. The reports must be comprehensive and reflect the type of content SSA has specified. The reports must be reviewed and signed by the physician who performs the examination.

This program policy statement outlines the major requirements. More detailed guidance is being prepared and will appear in our Program Operations Manual. The detailed guidance will include statements as to the elements which must appear in an acceptable medical report in the more commonly encountered medical areas such as internal medicine, orthopedics, psychiatry and neurology.

State Consultative Examination Procedures.—We will facilitate the ability of State agencies to share information among themselves on procedures that have improved the consultative examination process.

Techniques for Assuring Quality Examinations and Reports.—We will continue to investigate techniques the States can use to assure quality examinations and reports. My staff recently visited the American Medical Association. The AMA suggested we look into peer reviews of consultative services through such organizations as the American Society of Internal Medicine, medical foundations and State medical associations. We are following through on this advice.

Federal Process for Monitoring the Effectiveness of State Management of the Consultative Examination Process.—We will monitor the adequacy of State consultative examination practices to ensure the integrity of the evidence being obtained. We will also carefully assess any significant changes we or the States make for their impact on processing time, program costs, adequacy of documentation and State workload management.

Quality Assurance Assessments.—We will see to it that our quality assurance process includes an evaluation of the quality of consultative medical reports that will bring to light problem areas.

Federal Guidelines for Special State Oversight of Volume Sources.—We will continue our study of the need for special oversight of volume sources and the techniques that might be used to accomplish it. We will issue additional guidelines spelling out State responsibilities in this area.

The steps I have outlined here are the ones we have identified as needed at present. We believe there is more to do and will continue to give our close attention to this issue.

SUMMARY

To summarize, the number of disability claims being processed by the State Disability Determination Services is substantial and with the required periodic continuing disability review, increasing. By fiscal year 1982 we anticipate that 40 percent of all determinations will require consultative examinations. We anticipate total obligations for consultative examinations in fiscal year 1981 will reach $137,400,000. This level of expenditure makes it crucial that the consultative medical examination process be handled effectively at all levels. We have provided substantial guidance on State responsibilities through regulations and administrative guidelines. We intend to clarify and expand this direction. We will continue to set the objectives and goals that need to be achieved in the consultative examination area. However, we will continue to allow the States freedom to manage the selection and maintenance of the networks of physicians they use for consultative examinations, and to use their fee schedules and their authorization processes within their agencies. We will facilitate the exchange of information among State agencies on successful techniques being used at the State level to manage these responsibilities. We will improve our monitoring of the consultative examination process to identify problems and determine the need for possible changes.

The Social Security Disability Amendments of 1980 directed the Secretary to issue, through regulations, performance standards for State agencies to follow in making disability determinations. We are satisfied that we have the necessary flexibility under that legislation to resolve any known problems in this area and consequently have no recommendations for any legislative changes.

Mr. PICKLE. We thank you, Mr. Crank, and we appreciate your testimony.

The Chair first—I have some questions, but I first, I would yield to the chairman of the Oversight Subcommittee, Mr. Rangel, if he has questions.

Mr. RANGEL. I am going to be submitting a list of questions which I hope, Mr. Crank, your agency would respond to at a later date.

Your testimony makes it appear as though there are no problems that your agency believes it cannot handle, that you have sufficient flexibility in the regulations to do what you believe has to be done. Yet, many of us have a constituency problem with volume providers and believe that those who make the allegations don't have the ear of the Social Security Administration. That is to say that we don't have any doubt that you are listening to the American Medical Association, but we don't know whether you are listening to most people that have to go through these volume providers. You don't have the problem with the process of volume providers as it is today. You will leave it up to the doctor and the American medical profession as to the number of cases that can be processed by a doctor.

Mr. **Crank**. We believe the basic responsibility for managing that process, including the number of examinations that can be handled under a given arrangement with a consultant is a matter that can be best handled and managed at the State agency level. Allegations about the volume of examinations being done by one source on any given day do not take into account all circumstances such as the mix or the type of examination required. Not all examinations are full-fledged internal medicine examinations. Some are highly specialized and only require inquiry into specific allegations or problems.

We believe that since the State agency is the organization responsible for making the disability determination under the guidance and in accord with requirements set forth by the Social Security Administration, they are in the best position to make the judgments about what can be handled by what sources and in what volume. Clearly, we have a responsibility to oversee that, and where we have problems with what the State is doing and what decisions they are making, we step in and provide——

Mr. **Rangel**. We don't know what you do. Mr. Pickle has asked for a summary of how you use these volume providers. Your testimony doesn't shine any light on it. I get the general impression that you have a handle on all of the problems that have been coming up, and there is good reason why some of these problems have reached the courts, or why national attention has been focused on them. But that, generally speaking, you have it under control. We don't know that, because you have not shared with us the summary of how you use these volume providers. We need some type of a sharing of that information so that we specifically can go back to our jurisdictions to see whether or not you are right, or whether you do need some help, whether or not there is an adequate supervision, or whether or not the whole thing is being operated by the American Medical Association.

Mr. **Crank**. Chairman Rangel, we don't have all of the information on how they are being used. As I indicated in my testimony, we are getting that kind of information now from the States. It is very much incomplete, and we do need more information. Chairman Pickle has asked us to share that information with him. I believe in a recent communication to him the Commissioner has indicated that when that information is completely developed and we have obtained it all——

Mr. **Rangel**. What time frame? You knew you were coming here. Did the Commission indicate what you should tell us as to when we can expect to get that information, because we can't make any legislative decisions until we have it.

Mr. **Crank**. We find that a number of States are having difficulty in getting for us the kind of specifics we have asked for.

Mr. **Rangel**. What States? You know, we can't wait until—I don't think we are going to be as flexible as you are, and so when you are having a problem, you are going to have to share that with us, so we don't think that you are the problem.

If States are not cooperating, you have to tell us some kind of way what your problem is in getting us the information, because we get communications from you indicating that you do not believe performance of consultant physicians require regulations by you, and that State agencies overall are effectively monitoring the quality of consultative examinations purchased. We can't argue with you because you are on the firing line. You are out there. When these things happen we have to assume that you are in charge.

Then you turn around and say that you are creating new guidelines, new monitoring and closer supervision. It is not consistent. It just doesn't make sense to we lay people that on one hand you don't need any supportive assistance, that everything is under control. Yet, on the other hand, the whole thread of your testimony this morning is, "but we are tightening up—closer supervision, taking another look." Meanwhile, we can't do anything until you complete your summary, which now is dependent on the States that we are saying that we have a responsibility to monitor their performance.

So I don't want to embarrass you, but you are going to have to give us something to work with, because you are putting us in a no-win situation. We can't even give you guidance as to what the thrust of the Congress is until the people that we are concerned about report to you. Then you tell me when we have a problem with mass production by doctors that you are listening very carefully to the American medical profession. They will be giving you some advice and guidance on how to best handle it. That is like going to the fox asking how to take care of the chickens, in my opinion.

But then you are the professional here and I am willing to listen to how you are going to handle it. I don't think you are ready for these hearings, because you haven't got all the evidence in to respond to our concerns. So I guess what I will do is to submit the questions prepared by staff to you for an answer, because most of these questions will be dependent on information that you are able to get from the States.

Then I would ask, do you have a time frame in which we expect to get this information?

Mr. CRANK. Yes. We believe we will have all of the information in from the States within the next 2 to 3 weeks. And then we will complete the analysis of that within probably about a 2-week period after that.

Mr. RANGEL. Well, I wish I had known that, because I would have had the hearings delayed for 2 or 3 weeks. In any event, I will have my questions, Mr. Chairman, submitted to the agencies, and so perhaps they could be incorporated in the record after you receive the information from the States.

You know our problem. You know your problem.

Mr. CRANK. Yes.

Mr. RANGEL. Maybe we can crystallize it after you have garnished the information we need. Thank you.

[Information is to be provided when obtained and evaluated by SSA. It was not promised in time to complete this record.]

Mr. PICKLE. And, Mr. Rangel, the Social Security Subcommittee will also submit additional questions to the SSA for answers.

[The questions and answers follow:]

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

NOV 3 1981

The Honorable J. J. Pickle
Chairman, Subcommittee on
Social Security
Committee on Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are the responses you requested in your letter of September 29, 1981, to the questions raised as a result of the hearing of September 18 on the use of volume providers to perform consultative medical examinations.

Also enclosed is information on our investigation of Drs. Johnson, Byers and Lipman. Information you requested regarding use of volume providers in each State, including dollar earnings from performing consultative examinations for Drs. Thurman and Thurman and Drs. Johnson and Byers, is also enclosed. However, we have listed the dollar earnings for other volume providers without identifying the names of the providers, based on a discussion with Mr. Fred Arner.

The Social Security Administration is committed to monitoring consultative examination practices in the States, and especially the use of volume providers, to assure that the process is cost-efficient and provides the high quality medical information that is needed to make correct disability determinations. I want to assure you that we are continuing to investigate the consultative examination process and are taking action to improve this process as quickly as possible.

Sincerely,

John A. Svahn
Commissioner

Enclosures

Question (l) : Mr. Crank stated at the hearing that Social Security did not have information as to whether cases which contained medical reports from "volume providers" had a higher or lower denial rate than cases from other providers of consultative examinations. Could we possibly get this information on some type of sample basis or information already provided by the States?

Answer : SSA does not have this information and it is not readily available from the States.

SSA is planning to modify its quality assurance (QA) review to get this information from the States although it will take some time to obtain. Because our QA system is based on small samples that are valid only after several samples, we estimate it will take several months to have valid data on this subject.

(a) : If this information indicates a higher denial rate, how would you explain this phenomenon?

As stated above, we do not have information on denial rates for volume providers.

(b) : Do you have any information on a national basis as to the number of complaints received on volume providers as compared with other consultative physicians?

We do not have the information on a national basis. However, several States have indicated that the frequency of complaints lodged against volume providers was about the same as that for other providers.

Question (2) : Both of the States which testified before our Subcommittees complained about the problem of inadequate fee schedules for consultative examinations. Pennsylvania's fees have not been changed since 1974 and Tennessee since 1978. Should SSA establish these schedules for such examinations or continue to leave this decision to the States? What would be the advantages or disadvantages of SSA setting such examination rates?

Answer : Some States do have inadequate fee schedules for consultative examinations. Federal/State regulations, which became effective June 1, 1981, should help to overcome this problem.

Sections 404.1624 and 416.1024 of the regulations provide that the State rates of payment for consultative examinations can be as high as the highest rate paid by Federal or other agencies in the State for the same or similar service. This provision may permit the States to set higher fee schedules than they previously could since the rate payable in each State was limited to that of the State's regular programs.

In the past, States have opposed having the Federal Government set rates, because they viewed this as an intrusion into their management prerogatives. Establishing national rates of payment could lead to other kinds of problems. For example, in some States the rates would be lower than prevailing local rates.

We think the determination of fee schedules should be left to the States so that they can take local conditions into account. SSA regional staff will continue to assist the States in ironing out problems with fee schedules.

Question (3) : At the hearing, Congressman Bailey asked about your inquiry to the States which was dated July 27, 1981, about volume providers. How many States met the August 3rd deadline you imposed? List the States that did not meet the deadline and the date on which they actually did submit their answers.

Answer : Our teletype of July 24, 1981, requested information from each State about the consultative examination process, not just about volume providers. While we asked that some reply be made by August 3, we recognized that some of the information would not be readily available. All States, except one, submitted partial replies by August 7, but the information submitted was not sufficiently complete to be incorporated in my letter to you on September 4, 1981.

The following 15 States provided complete information as of the dates shown:

July 31: Alabama, Connecticut, Mississippi, North Carolina and Tennessee.

September 10: Illinois, Indiana and Michigan.

September 16: Nebraska

October 2: Maine, New Hampshire and Vermont.

October 7: Pennsylvania.

October 15: Arkansas and Texas.

The information from 37 State DDS's remains incomplete. These States have advised us that supplying the additional information would be difficult for them either because their records are not kept centrally or that tabulating the data would require excessive additional work hours. While the information from the States is not complete in all respects, it has been sufficient for us to determine some areas where we can help the States improve their management of the consultative examination process. We are currently developing a format of the information we think necessary for our overall monitoring of the consultative examination process.

Question (4) : In your report which resulted in the reinstitution of Thurman and Thurman it appears you consulted extensively with the State agencies, but very little with the legal aid attorneys who brought the charges. They feel that they were not consulted. Why did you not question them more on what evidence they had to support the allegation?

Answer : The investigation of Thurman and Thurman was conducted primarily as a result of the allegation of fraud by Judge Glen M. Williams of the U.S. Western District Court of Virginia. We consulted extensively with the State DDS's because they are responsible for the selection of consultative examination providers and supervision of the consultative examination process. We analyzed a number of Thurman and Thurman examination reports and were briefed on DDS activities in working with the Thurmans to improve their consultative examinations and reports.

We also considered the results of a 1980 study of the Thurman and Thurman operation conducted by the Tennessee DDS in which claimants were contacted between the time they underwent consultative examinations and the date they were notified of the decision on their claims. This DDS study showed the Thurman and Thurman operation in a favorable light.

Moreover, in the course of the investigation, we talked with, and received correspondence from, legal aid attorneys about the Thurman and Thurman issue. On July 29, 1981, the Tennessee DDS administrator, the local SSA District Manager, and representatives of Tennessee Legal Services Group met in Nashville. Legal aid concerns were aired at this session. Consequently we believe we had sufficient information about legal aid concerns to properly and fairly complete our investigation of Thurman and Thurman.

Question (5) : Mr. Crank stated on page 8 of his testimony that "we have not had a disciplined process that permits us to obtain continuing information on the effectiveness of the States' management of their consultative examination process." Describe the process you do have in a little more detail. Did this process give you enough information to make an informed decision on the initial suspension of Thurman and Thurman?

Answer : The States have established a variety of approaches to manage their consultative examination process. Some can provide formal records and study findings on each consultative examination source; others have a more informal system. Most States are fully cooperative in responding to our requests for information regarding this and other areas of concern.

We obtain information on the effectiveness of the States' management of their consultative examination process in several ways. We receive continuing information on projected expenditures for consultative examinations as well as regular reports on obligations. SSA regional offices hold regular meetings with their State medical relations officers. SSA's regional disability program administrators make regular visits to the States to review their operations and discuss any initiatives or problems. The regional offices have also conducted periodic fiscal and administrative management reviews, which include the consultative examination management area. In addition, State quality assurance units have been doing special studies annually in the consultative examination area.

While these various mechanisms have existed for some time, they have not been specifically directed to produce ongoing, organized information on a national basis about State management of the consultative examination process. Nor did these mechanisms give us a basis to act on the Thurman and Thurman situation without further inquiry. For those reasons we are taking the steps outlined by Mr. Crank in his testimony to improve our monitoring of the process.

Question (6) : Mr. Crank stated on page 11 of his printed statement that his staff recently visited the American Medical Association to get some ideas on how to get quality examinations from volume providers. Specifically when did your staff check with the AMA? Was it before or after the Tennessee situation had been brought to your attention?

Answer : Social Security Administration staff met with members of the American Medical Association on August 18, 1981. Subsequently, the staff spoke with members of the American Society of Internal Medicine and the Maryland State Medical Association. These meetings were held after the Tennessee situation had been brought to our attention.

Status Report on the SSA Investigation of Drs. Johnson, Byers and Lipman

This investigation is intended to evaluate the adequacy of the services and reports provided by these physicians to State DDS's and the relationship of Dr. Lipman to Drs. Johnson and Byers. Thus far, we have learned that Dr. Lipman developed the idea of, and owns, the mobile examination vans used by Drs. Johnson and Byers. In addition, Dr. Lipman generally provides backup support for Drs. Johnson and Byers, as well as for other medical organizations, in the form of medical transcription services, and interpretations of x-ray, electrocardiogram, and ventilation studies. The latter activity is performed by Dr. Lipman and associated specialists in the fields of cardiology and radiology. We expect to report on our findings and recommendations before December 1981 and will make our report available to the Subcommittee.

Following are the steps SSA staff has taken or will be taking during the investigation:

1. We visited the Indiana, Michigan, New York, Pennsylvania, Virginia and West Virginia DDS's to assess the activities of Drs. Johnson and Byers.
2. We and the Michigan Disability Determination Services' personnel met in Troy, Michigan on October 2, 1981, with Drs. Johnson and Byers, and an associate, Dr. James Henderson, and their attorney, Mr. Ken Adams.
3. We met in Baltimore with Dr. Richard P. Lipman on October 13, 1981, concerning Internal Medicine Associates, a Grand Rapids-based volume provider in which he owns a controlling interest, and his medical transcribing business.
4. We plan an onsite visit to the Miami, Florida office of Dr. Lipman in early November to assess the quality of his medical reports.

Summary of Reports by State Agencies on States' Medical Consultative Examination Practices

Background

SSA regional commissioners provided reports by the disability determination services (DDS) in their respective regions on several aspects of the management and oversight of DDS consultative examination (CE) operations. A summary of their reports follows:

- Describe the CE panel including numbers and types of providers as well as any special arrangements such as block time allotments or bulk provider agreements used

  The CE panels in most States are described as including a variety of medical specialties, medical and laboratory facilities, psychologists, audiologists and a few other nonmedical resources. We have provided a narrative that describes primarily gross numbers. (See attachment A.)

- Describe the process used in selecting the CE source to be used in each case

  It was obvious that the approach taken to selection of CE sources varied from State to State, although there does appear to be some similarity within regions. While the underlying concepts of proximity, specialty, timeliness of scheduling and reporting, and quality of report are considered by most States, the relative weight or importance of these factors varied from State to State. Several States equalized authorizations by rotating appointments within each specialty. Occasional States reported such factors as fees charged or block time commitments could be decisive. Several reported considering the attending source if that person were on the panel. (See attachment A.)

- How many CE sources (i.e., separate billing entities) were used by each State?

  The Atlanta Region appeared to use the most CE sources consistently with a reported 5,881 for 1981 to date. The San Francisco Region appeared to represent the second highest. The Atlanta Region appeared to use mostly clinics and groups, rather than individual physicians. The major CE providers appeared to have changed little over the 3-year period 1979 through 1981; however, money amounts paid to these sources have generally increased. In some cases, CE sources used had little relationship to the number of sources listed. (For further detail see attachments A and B.)

- What was the range of payments for CE sources?

  Reports disclosed ranges from lows of zero dollars for services provided by some sources without charge to a high of $1,048,513 paid in Illinois in 1980. The lows ranged from zero dollars to $25, highs ranged from $250 to the $1,048,513 figure previously cited. The highs were most frequently noted where groups of doctors constituted the CE source. (See attachment B.)

- Top 10 Sources

  Based on the information provided, the States within the Atlanta and Chicago Regions appeared to be paying their top 10 sources the largest money amounts. (See attachment C for further details.)

- Reviewing the quality and performance of CE providers

  Our Program Operations Manual System (POMS), Disability Insurance, section 2027G, describes the State DDS's responsibility in obtaining and reviewing reports of consultative examinations as: (1) seeing the report is obtained as quickly as possible, (2) reviewing the report to determine whether the specific information ordered has been furnished, and (3) where the report is inadequate or incomplete asking the consultative physician to furnish the missing information or prepare a revised report. POMS section 2003 describes the DDS physician's role as including review of consultative reports for deficiencies in content and recommending ways to avoid deficient reports.

  Most States indicated that CE reports are routinely reviewed for adequacy and completeness as a part of the development and decision process. Some described this responsibility as being shared by the disability examiners, physicians, and quality assurance staff. A few described this as primarily the responsibility of the medical relations officer, supervisors, quality assurance, or examiner staffs. A few others described it as the responsibility of their chief medical consultant or their review physicians. Several reported they conduct special reviews when the panelist first starts performing examinations for the DDS, some reported subsequent spot checks. Two States advised they have no special procedures. A few States further indicated they assess the timeliness of their panelists' services, claimant satisfaction, and appropriateness of charges. No one specifically reported studies designed to assess the accuracy of the panelists' clinical evaluations and laboratory services. (Attachment D provides a State-by-State breakdown of approaches to reviewing quality and performance of the providers.)

Where providers' reports are deficient, they generally receive telephone calls from the chief medical consultant, the medical relations officer, or a member of the supervisory staff. A few agencies maintained records and monitored a few subsequent reports. If there are repeated deficiencies, they generally removed the provider from the panel. A few States reported they will also remove a provider from their consultant panel if he persists in reporting too slowly.

- Describe agency procedures for handling complaints received about CE providers

Most States reported that when they received a complaint, they contacted the claimant and the source to establish what happened and then went on to resolve the problem. The method of review and the route for taking action is variable. Agency physicians are not always or perhaps not commonly involved. In some States, the DDS administrator handled all complaints. A few States advised that where the complaint involved the provider selected to do an examination, they would reschedule with another provider. Two States reported that where the adequacy of the examination was challenged, they scheduled a second examination with another provider. Several States described specific investigations of complaint, but it was not clear what was done.

Very few States provided a record of the number of complaints they received. A few States advised they had received no complaints. New York, New Jersey, and Tennessee reported the highest volume of complaints. The majority of the States reported complaints generally surfaced after the disability claim was denied.

The most frequent complaint seemed to be that the examination was too brief. There were several complaints the doctors failed to check all the problems. A few claimants complained about long waits, untidy or inadequate facilities, or unsanitary conditions. There were occasional reports of roughness and rudeness.

A few States indicated that if they felt the complaint was justified and they were not satisfied the problems had been resolved or they had repeated complaints, the provider would be dropped from the panel. (For further detail see attachment E.)

Attachment A

1. CE PANEL NUMBERS, TYPES, AND SPECIAL ARRANGEMENTS
2. PROCESS USED IN SELECTING CE SOURCE

Boston Region

Maine--The CE panel includes 76 private practice units which represents 71 individuals and 5 corporate groups. There are no block time allotments or special bulk agreements.

The CE placement unit selects the source on the basis of availability at the time. DDS examiners and physicians have no say in the process.

Connecticut--There are 307 physician panelists, 14 of whom provide block time.

The CE source is selected on the basis of geographical location, specialty, age of case, and availability (or timeliness). There are two exceptions to the rule. First, if there is block time in a particular area, cases may be set aside to fill block time appointments. Second, if there is no specialist available (timely appointment), the case is reviewed to determine if a substitute specialist could be used.

Massachusetts--The CE panel totals 560. These include block CE panelists, group practices, hospitals, and clinics. There is one major laboratory service provider that performs all lab work statewide.

The CE source is selected on the basis of timeliness, quality, location, and specialty.

New Hampshire--There are about 250 CE panelists. All are in private practice. There are no block time allotments or special arrangements.

The CE source is selected based on specialty, availability (timeliness) and geographic location.

Rhode Island--The CE panel consists of 41 different providers. These include individual MD's and two institutions: Butler Hospital (psychiatric) and Rhode Island General. There are no block time allotments or special agreements.

Sources are selected by the CE appointment clerk only. This is based on earliest possible appointment and quickest response time. Neither examiners nor staff physicians have a say.

Vermont--The CE panel includes 119 individuals and 11 group associations. The only bulk agreements involve one orthopedic examination and two psychiatric examinations per week.

The source is selected by the CE placement unit depending upon the geographical area nearest the claimant which has the needed specialty. The attempt is made to spread CE's around as fairly as possible.

New York Region

New York, New Jersey, Puerto Rico--The CE panel in each DDS in the New York Region is made up of individual physicians, CE facilities, and laboratories. Most physicians as well as bulk providers take appointments only on specific days of the week.

The New York CE panel consists of 3,000 members which includes individual physicians in most specialties and 10 bulk providers. The New Jersey CE panel consists of 460 members, 113 medical groups which consist of 3 or more physicians, and 1 bulk provider. The New Jersey DDS is the only one with some physicians who have block time allotments. The Puerto Rico CE panel totals 172 CE MD's and 61 laboratories and X-ray facilities. There are no bulk providers.

The DDS examiner designates the specialty required, specific tests, and claimant's address. A clerk selects the source. Sources are rotated. The same process exists in all three States.

Philadelphia Region

District of Columbia--The CE panel consists of 76 providers in 12 specialties. We did not receive information as to block time or bulk providers.

Physicians selected at random to assure spread and according to earlist appointment date.

West Virginia--Providers total 162 in 10 specialties. There are three providers of block time service.

The source selected depends upon earliest appointment and proximity of claimant.

Delaware--The CE panel totals 89 in 15 specialties. Block time exists with four physicians.

The DDS examiner determines the examination needed. A secretary arranges the examination with a physician on a rotating basis and on the basis of specialty and proximity to the claimant.

Virginia--The CE panel totals 809 in 14 specialties. Block time exists with seven providers.

Sources are selected according to location, specialty, and prompt reporting.

Pennsylvania--The CE panel totals 1,533 providers in all specialties.

Special arrangements exist with six providers.

CE's are screened and approved by supervisors and staff physicians.

Selection is based on rotation, location, scheduling, etc.

Maryland--The CE panel consists of 846 private physicians and most major hospitals. The DDS schedules directly with approximately 25 private laboratories. There are no bulk providers. The only block time arrangements are with individual doctors in the outlying counties.

The process used in selecting a CE source was not described.

Atlanta Region

Alabama--The CE panel consists of 768 providers of medical services in 20 specialties, the largest number of which (175) are internists. In addition, the services of 17 hospitals are used.

Block time arrangements are used in nine instances, seven arrangements involve a single MD providing the CE service on a scheduled basis, the other, scheduled services by a group of five physicians. One Ph.D. in psychology works on a block time basis.

In general, examination scheduling is done by a CE scheduling section which selects the physician from the CE panel list by specialty on the following criteria:

- Criterion 1--Claimant address;
- Criterion 2--Type of examination needed;
- Criterion 3--Capacity for handling laboratory studies.

Florida--The CE panel consists of 2,259 providers of medical specialties. Again, internists represent the largest number of providers.

Only two MD's are involved in block time arrangements.

In general, the selection process involves the bulk providers but the DDS examiner is responsible for the provider selection.

Georgia--The CE panel consists of a statewide VR panel of specialists totaling 1,739. In addition, the DDS uses its own panel of 427 specialists in 14 specialties.

There are no block time allotments or bulk provider agreements.

The DDS examiner is responsible for provider selection.

Kentucky--The panel consists of 226 providers in 12 specialties. Block time is utilized extensively.

The DDS examiner requests the CE which, in turn, is scheduled by a scheduling clerk on a rotational basis unless a particular source is requested.

Mississippi--There is no CE panel as such, but in FY 1981 2,141 providers were used. The DDS deals with all licensed physicians within the State provided they meet five critera that relate to quality, timeliness, etc. The DDS utilized treatment facilities in five instances involving 71 MD's and two psychologists.

The DDS maintains a centralized CE appointment unit which has the responsibility for arranging and scheduling appointments by physicians on a log time basis.

North Carolina--In 1981 the DDS utilized 694 providers in the major specialties. Two bulk providers are used and a number of physicians provide block time.

The DDS examiner may specify a particular provider however, routinely, examinations are scheduled by a CE control unit.

South Carolina--CE panel is managed by the parent VR agency involving 1,836 physicians including all specialty groups. The DDS does not have any block time allotments or bulk provider agreements.

The DDS examiner designates the specialty type and a clerical in the DDS schedules the examination on a rotating basis.

Tennessee--The CE panel consists of 498 providers in all specialties. There are no block time allotments or bulk provider agreements.

The DDS examiner selects the source based upon the factors of type of examination, claimant proximity, etc.

Chicago Region

Illinois--There are 1,077 panelists of whom 994 are single providers. The remainder are multiple providers. The block time process is used.

The criteria utilized in determining the source are location (proximity of claimant), specialty and timeliness of report, and availability.

Indiana--The panel consists of 1,227 sources of whom 10 are multiple providers. Block time arrangement are used by volume sources. A CE appointment clerk selects the source based on: (1) type of examination and testing, (2) proximity, and (3) timeliness.

Michigan--There are 6,292 sources. Of these, 6,215 are single providers and 77 are multiple providers. There are no special arrangements.

Appointment clerks are responsible for arranging appointments. Numerous factors are considered which include, in addition to specialty, geographical location, equipment, and such other factors as language barriers, frequency with which source has been used, transportation costs, economy, etc.

Minnesota--There are 725 sources in Minnesota which includes 438 single sources and 287 multiple sources. Special arrangements include block time allotments and mobile examinations.

Factors involved in selecting the source are specialty, availability, timeliness, and the volume the provider has performed. Rotation is ultilized.

Ohio--There are 550 CE sources. Of these, 70 are multiple providers and 480 are single providers. Block time is utilized.

Source selection is performed by the consult department. Upon assignment, a consultant considers the geographic area, availability of studies requested, transportation and distance from the claimant's home to the consultant's office, availability of timely appointment, and expected total turnaround time of the report.

Wisconsin--There are 1,200 sources split equally in number between single and multiple providers. Block time allotments are utilized with a few sources, but they are infrequent.

The following are considered in determining source selection:

1. Geographic location in proximity to claimant;
2. Whether or not the source is able to perform the needed tests;
3. Whether or not the source is able to service a claimant of a particular age group; and,
4. Whether or not the source is available within the DDS time frames.

Kansas City Region

Iowa--The Iowa CE panel consists of 612 active vendor entities; of these 82 are clinics and 79 hospitals. The clinics and hospitals total 310 physicians. There is one special arrangement with Midwest Medical Services which conducts 70-90 CE's per month.

The CE source is selected on the basis of specialty needed, the proximity to the applicant, the availability of appointments, and timeliness of reporting.

Missouri--The CE panel consists of qualified specialists in all fields. During the past three years, over 2,600 sources have been used. These physicians are all in private or clinic (group) practice. No block time or bulk provider agreements are used.

All qualified specialists that will provide the services needed at the price we can pay are used. They do not specify the process they use to select the source in each case.

Nebraska--The CE panel consists of 286 vendor entities including hospitals and clinics. There is not very much volume with any single source.

The CE is selected on the basis of specialty needed, proximity to the applicant, availability of appointment, and timeliness of report.

Kansas--The CE panel consists of specialists of the usual specialties. There is one bulk source, Central Medical Consultants, which has four physicians.

The DDS has a centralized facility for scheduling CE's. They are scheduled with the panelist who is appropriate for the impairment, nearest the claimant, and has the earliest appointment time.

Dallas Region

Arkansas--Currently, there are 170 CE panelists. Arkansas has no contracts with providers of medical services. Block time is not used. Appointments are made with individual physicians even if part of a group practice.

The examiner initiates the CE request which is reviewed by the supervisor and, in turn, sent to the CE development unit. The CE development unit considers the type of exam and procedure requested, the geographical location of the claimant and of panelists qualified to do the requested exam. He/she calls to secure an early appointment date. If an appointment cannot be secured within a reasonable time, an alternate source is contacted.

Texas--The CE panel totalled 773 physicians in 1981. CE requests are forwarded to a centralized CE unit for scheduling. Source selection is made on a rotational basis within time limits of 8 days to 3 weeks for appointment. Other selection criteria include location and type of examination. Attending physicians may be used if they are panel members.

Oklahoma--This agency had a pool of 2,207 CE panelists during the period, January 1980 through December 1980. Appointments are scheduled with individual physicians even if part of a group practice.

Oklahoma operates on a modular system based on geographic area. All CE requests are reviewed by module supervisors. The appointment clerk in each module selects a physician and schedules the appointment. Physician preference is based only on quality and timeliness of reports.

New Mexico--CE panelists totalled 498 for 1981. There are no contracts or letters of agreement with any providers of medical services. Also, block time is not used.

A centralized CE unit receives all requests for scheduling. Physician selection is based upon factors such as location, cost, adequacy of reports and specialty. The unit attempts to assure an equitable distribution of CE requests, particularly in Albuquerque which has a surplus of physicians. Attending physicians are generally not used as they tend to repeat findings already known.

Louisiana--Louisiana CE panelists totalled 700 in 1981. Louisiana has no contracts or letters of agreement with any providers of medical services. Block time is not used. All appointments are scheduled with individual physicians even if part of a group practice.

The State of Louisiana has a state office and three area offices--Baton Rouge, New Orleans, and Shreveport. The area offices do not have centralized CE units. The disability examiner selects a CE physician from an updated register of CE panelists and schedules the appointment. Selection criteria include type of exam, geographic location, and quality and timeliness of reports. Although attending physicians may be used if on the panel, the DDS prefers to use another source to avoid possible subjectivity in the report.

In some areas equitable distribution among panel members is self-controlling due to the limited number of CE sources. Basically, the CE physician determines the amount of business received by the quality and timeliness of his/her reports.

Denver Region

South Dakota--The CE panel consists of 147 individual providers in the usual specialties. Special arrangements have been made with a group of four internists, an individual internist, and a specialist in physical medicine whereby appointments are scheduled in advance with names called in later.

The selection of the CE source is made by the examiner subject to review.

Utah--There is no formal CE panel, but utilizes 88 different physicians. There are no block time arrangements.

Physicians are selected on a rotating basis within their specialty.

Wyoming--There is no formal CE panel, but uses 213 physicians, 19 hospitals, and 11 mental health counseling centers. Since physicians, especially specialists, are so scarce, providers are used in surrounding States. No special arrangements, block time, or bulk providers.

When selecting source they consider what is needed and location of nearest source.

Montana--CE panel consists of 192 physicians. No block time or bulk providers.

The selection of the source is made by the examiner.

North Dakota--CE panel consists of 100 physicians with different specialties.

No block time or bulk agreements are used.

Source selection is based on location, costs, type of specialty required, availability, and quality of exams and reports.

Colorado--CE panel consists of 775 medical sources in all specialists. There are no block time arrangements.

Physicians and facilities are taken on rotation basis. The DDS physician determines the examination needed and clerical employees select specific sources.

San Francisco Region

Arizona--The CE panel consists of approximately 200 members used on a regular basis. In the Phoenix and Tucson areas a complete range of medical specialties are under contract to the DDS.

Nineteen consultants have block time allotments, and 25 percent of the consultative examinations are scheduled in block time appointments.

Block time allotments are filled first because of scheduling precommitments. The remaining 75 percent of the CE workload is evenly distributed among the remainder of the panel members.

Hawaii--There are currently 164 medical consultants on the CE panel. The panel consists of all medical specialties. The DDS does not use block time allotments because it cannot guarantee a sufficient number of referrals.

Basically, CE sources are selected on a geographical basis. Accessability to X-ray and laboratory facilities and availability of the earliest appointment are also taken into consideration.

Nevada--There are currently 178 medical consultants on the CE panel. The panel represents 25 medical specialties. Neither block time allotments nor bulk provide agreements are used.

Source selection is made on a rotation basis considering also specialty required and geographical location.

California--As of April 1981, the DDS maintained 4,519 individual CE panelists.

Block time allotments are not utilized.

The source is selected on a rotational basis with respect to geographical location, availability, timeliness, etc.

Seattle Region

Idaho—The DDS utilizes 299 providers in all specialties. There are no block time or bulk provider agreements.

The CE source is chosen by the examiner who initiates the CE request.

Oregon—The CE panel totals 496 physicians. The DDS utilizes only one block time source having several doctors.

The need for an examination is determined by a staff physician.

Choice of source made by clerical based on specialty, proximity, and the timeliness of the appointment.

Alaska—The DDS apparently has 43 CE panelists representing the major specialties. Those physicians who provide acceptable reports at the most reasonable fees are utilized first. Those charging higher fees are only used if absolutely necessary. There are no special arrangements, written or otherwise, in regards to block time allotments or bulk provider agreements.

The members of the CE panel schedule claimants in with their regular patients.

Washington—Although numbers were not furnished it was stated that Washington does not have an over abundance of CE panel members. Those providing the type of report required at the most reasonable fee are the ones utilized first. Providers charging higher fees are utilized only where absolutely necessary due to scheduling problems and/or travel problems for the claimants.

There are no special arrangements in regards to block time allotments or bulk provider agreements.

The CE procedure begins with the examiner. The request is routed to a physician for concurrence and subsequently to a case consultant to schedule the appointment. Appointments are made with physicians who are located as close as possible to the claimants address.

Attachment B

	Number of CE Sources (Separate Billing Entities)			CE Payment Range		
	1979	1980	1981	1979	1980	1981
Boston						
Connecticut	307	307	307	$ 32 - $ 16,793	$ 40 - $ 30,524	$ 40 - $ 34,071
Maine	172	172	172	32 - 23,001	32 - 17,112	32 - 18,304
Massachusetts	300	350	429	50 - NA	50 - 91,658	75 - 143,739
New Hampshire	320	280	250	70 - 16,010	70 - 6,860	70 - 8,540
Rhode Island	81	71	82	NA - NA	35 - 13,680	40 - 21,285
Vermont	119	119	119	20 - 7,522	25 - 29,987	25 - 25,935
New York						
New Jersey	429	516	594	NA	NA	$ 40 - $ 10,000
New York	3,000	3,000	3,030	NA	NA	NA
Puerto Rico	233	233	233	NA - $ 14,160	NA - $ 32,550	NA
Philadelphia						
Delaware	NA	108	121	NA - $ 20,515	NA - $ 16,600	NA - $ 16,464
Dist. of Columbia	71	59	79	NA	NA	NA
Maryland	846	846	846	$ 0 - 46,564	$ 0 - 37,398	0 - NA
Pennsylvania	1,533	1,533	1,533	0 - 168,000	0 - 642,000	0 - 476,000
Virginia	68	87	313	0 - 83,065	NA - 91,773	NA - 119,350
West Virginia	NA	273	NA		11 - 283,874	NA
Atlanta						
Alabama	424	458	532	$ 20 - $ 45,517	$ 20 - $ 68,031	$ 35 - $119,930
Florida	NA	NA	838	NA	NA	52 - 173,847
Georgia	1,000	1,000	1,000	40 - 455,527	40 - 480,255	40 - 264,950
Kentucky	182	212	249	175 - 402,000	132 - 275,000	160 - NA
Mississippi	1,997	2,157	2,141	5 - 69,076	5 - 71,696	NA
North Carolina	632	605	694	0 - 238,101	0 - 236,293	0 - 158,392
South Carolina	427	427	427	NA	25 - 98,560	25 - 90,000
Tennessee	NA	NA	NA	25 - 727,446	25 - 804,488	25 - 599,300

NOTE: Some of the figures for billing entities do not correspond to the numbers cited in tab A. We are notifying the appropriate regional offices of these variations for any necessary action.

Chicago						
Illinois	500	600	525	$ 4 - $924,166	$ 4 - $1,048,513	$ 4 - $ 554,751
Indiana	200	240	240	45 - 149,278	52 - 367,644	65 - 358,850
Michigan	820	880	940	32 - 206,785	35 - 304,988	10 - 379,832
Minnesota	725	725	725	12 - 121,295	15 - 115,771	18 - 108,744
Ohio	550	NA	550	NA	60 - 212,404	50 - 386,890
Wisconsin	357	1,104	NA	10 - 46,872	2 - 34,283	NA
Dallas						
Arkansas	93	127	170	$ 0 - $808,452	$ 0 - $ 898,518	$ 0 - $1,112,580
Louisiana	500	640	700	NA	NA	NA
New Mexico	400	420	498	NA	NA	NA
Oklahoma	NA	2,207	NA	NA	NA - 70,598	NA
Texas	681	705	773	0 - 114,567	0 - 234,141	0 - 481,789
Kansas City						
Iowa	600	612	NA	NA	NA - $ 133,729	NA - $ 119,802
Kansas	151	176	NA	NA - $ 23,977	NA - 56,769	NA - 86,539
Missouri	1,089	957	561	$ 30 - 101,000	$ 25 - 121,700	$ 35 - 71,804
Nebraska	712	816	861	0 - 81,224	1 - 162,030	2 - 62,929
Denver						
Colorado	775	775	775	NA	$ 15 - $ 14,000	$ 15 - $ 10,000
Montana	192	192	192	NA	NA - 13,400	NA
North Dakota	NA	NA	NA	NA	NA	NA
South Dakota	256	260	262	$100 - $ 10,000	60 - 17,000	60 - 14,000
Utah	120	120	120	6 - 7,000	6 - 11,000	6 - 21,000
Wyoming	248	248	248	NA	NA	NA
San Francisco						
Arizona	NA	348	343	NA	$ 4 - $ 59,144	$ 4 - $ 49,750
California	4,600	5,000	5,054	NA	NA - 189,983	NA - 532,787
Hawaii	80	113	113	NA	NA	NA
Nevada	180	188	188	$ 10 - $ 14,528	$ 12 - $ 13,553	20 - $ 13,167
Seattle						
Alaska	NA	NA	NA	$ 89 - NA	$ 87 - NA	$122 - $ 118,758
Idaho	201	260	299	NA - $ 7,779	NA - $ 10,801	NA - 5,394
Oregon	NA	NA	496	NA - 13,642	NA - 90,462	NA
Washington	NA	NA	NA	NA	NA	NA - 93,741

Attachment C

Top Ten Providers

Region I--Boston

State

Connecticut	1979	1980	1981
	$16,793	$30,524	$34,071
	12,765	29,120	19,758
	12,053	28,865	18,044
	11,354	11,734	17,539
	7,603	11,526	13,463
	7,589	8,545	13,233
	6,871	6,305	11,412
	4,843	5,842	8,934
	4,697	5,037	8,052
	2,776	4,809	7,344

Maine	1979	1980	1981
	$23,001	$17,112	$18,304
	17,220	15,592	18,150
	11,781	15,375	16,335
	8,580	12,584	14,850
	6,050	10,890	14,553
	5,400	6,600	13,350
	4,500	6,050	12,915
	4,235	5,445	10,340
		4,840	10,120

Massachusetts	1979	1980	1981
		$91,658	$143,739
		90,294	112,039
		74,793	101,037
		66,501	93,537
		61,565	72,730
		39,886	38,480
		36,450	32,486
		22,590	24,845
		21,395	23,065
		12,825	16,655

NOTE: Years cited are on a fiscal year basis unless otherwise indicated. Where no dollar figures are provided for any year, information is not available.

New Hampshire	1979	1980	1981
	$16,010	$6,580	$8,540
	5,530	5,600	8,190
	5,530	5,600	6,300
	5,530	5,600	5,040
	4,270	4,480	4,200
	1,680	4,200	3,290
	770	2,170	3,080
	770	1,750	1,750
		140	1,020

Rhode Island	1979	1980	1981
		$13,680	$21,285
		12,760	13,970
		10,500	12,045
		10,260	8,030
		7,980	7,656
		5,940	7,150
		4,300	4,155
		3,500	3,080
		3,000	2,695
		1,600	1,980

Vermont	1979	1980	1981
	$7,522	$29,987	$25,938
	7,116	17,098	10,255
	3,690	10,577	9,625
	3,665	10,350	7,243
	3,280	8,062	5,583
	3,150	5,585	5,381
	2,800	5,560	4,962
	2,708	5,210	4,377
	2,634	5,086	
		3,900	

Region II—New York

State

New Jersey	1979	1980	1981

New York	1979	1980	1981

Puerto Rico	1979	1980	1981

Region III—Philadelphia

State

Delaware	1979	1980	1981
	$20,515	$16,600	$16,464
	13,008	15,902	15,014
	9,863	14,911	14,738
	8,922	12,495	13,505
	8,598	10,200	10,828
	6,319	7,719	10,665
	5,115	6,085	7,850
	4,574	5,300	6,070
	3,679	2,530	4,340
	3,422	1,950	3,725

District of Columbia	1979	1980	1981

Maryland	1979	1980	1981
	$46,564	$37,398	
	16,748	19,568	
	16,497	18,695	
	13,355	17,587	
	11,309	16,512	
	10,459	16,011	
	<10,000	15,095	
	<10,000	15,041	

< equals "less than"
Figures include VR payments

Pennsylvania	1979	1980	1981
	$168,000	$642,000	$476,000
	38,194	67,000	37,500
	38,122	35,900	33,000
	28,506	31,700	13,000
	24,865	27,000	11,500
	18,638	25,711	9,900
	17,040	23,988	9,500
	16,571	23,455	8,850
		21,958	7,500
		18,652	4,000

Figures are by calendar year

Virginia	1979	1980	1981
		$186,098	
		92,998	
		78,940	
		76,713	
		40,560	
		36,904	
		34,670	
		30,516	
		27,618	
		25,066	

Figures include VR payments

West Virginia	1979	1980	1981
	$95,462	$283,874	$235,330
	66,110	92,811	112,150
	54,720	53,229	86,116
	40,169	43,428	53,713
	38,805	41,144	46,773
	36,195	38,317	40,906
	30,269	34,412	38,484
	29,424	33,245	36,894
	25,711	21,664	26,448
	22,609	19,560	19,540

Region IV--Atlanta

State

Alabama	1979	1980	1981
	$45,517	$68,031	$119,930
	38,736	59,518	53,284
	37,440	49,798	48,398
	37,023	49,698	42,782
	35,827	42,177	39,128
	28,681	39,880	27,786
	26,014	33,767	26,485
	22,794	33,390	24,728
	21,275	29,992	21,542
	16,936	29,526	16,473

Florida	1979	1980	1981
			$265,947
			180,000
			128,371
			111,035
			91,760
			90,689
			75,958
			59,280
			45,264
			30,937

Figures represent the period 7/1/80-6/30/81

Georgia	1979	1980	1981
	$455,527	$480,255	$264,950
	158,753	195,167	120,736
	149,060	136,451	81,109
	66,073	98,792	55,518
	65,010	84,265	51,113
	57,670	67,768	47,685
	53,037	62,290	37,316
	47,058	60,927	35,590
	43,582	58,256	34,885
	42,365	54,065	31,365

Above includes VR expenditures

Kentucky	1979	1980	1981
	$402,000	$275,000	
	123,000	154,000	
	113,000	93,000	
	89,000	57,000	
	88,000	52,000	
	50,000	26,000	
	36,000	22,000	
	32,000	22,000	
	32,000	21,000	
	27,000	16,000	

Mississippi	1979	1980	1981
	$69,076	$71,696	$48,515
	54,544	71,478	46,980
	40,600	68,762	46,911
	37,842	64,329	41,544
	35,341	62,497	24,317
	29,900	39,425	23,553
	27,822	38,193	23,506
	19,930	34,888	23,437
	17,901	33,256	22,446
	16,101	29,977	21,436

North Carolina	1979	1980	1981
	$238,101	$236,293	$158,392
	109,393	125,241	68,409
	59,648	72,012	58,588
	45,190	69,398	55,986
	36,685	54,022	42,885
	32,880	53,904	34,802
	30,729	44,558	29,609
	29,069	37,366	28,509
	26,081	37,256	27,353
	25,939	32,456	20,584

South Carolina	1979	1980	1981
		$98,560	$90,000
		51,752	31,000
		26,156	25,030
		24,006	22,992
		23,731	21,666

	22,237	20,510
	20,487	20,330
	19,199	19,249
	18,356	18,565
	17,425	17,179

Above includes VR expenditures

Tennessee	1979	1980	1981
	$727,446	$804,488	$599,300
	111,067	118,111	96,304
	85,387	84,110	62,615
	73,661	69,461	58,437
	52,450	57,273	46,572
	51,456	55,260	46,461
	41,500	52,206	44,548
	39,470	45,788	42,212
	34,379	39,666	38,430
	32,463	35,772	32,750

Region V—Chicago

State

Illinois	1979	1980	1981
	$924,166	$1,048,513	$554,751
	243,780	576,945	450,535
	48,319	111,871	441,327
	39,712	55,044	417,946
	29,432	33,484	75,473
	28,529	25,610	55,224
	25,518	22,475	47,980
	22,792	18,324	32,366
	22,527	17,920	27,808
	21,100	13,008	24,217

Indiana	1979	1980	1981
	$149,278	$367,644	$358,850
	132,206	167,700	255,708
	130,424	156,126	187,155
	22,479	130,396	105,556
	21,961	63,276	93,191
	19,910	25,365	73,648
	9,745	22,901	72,925
	7,772	22,724	32,039
			27,300
			25,135

Michigan	1979	1980	1981
	$206,785	$304,988	$379,832
	187,532	252,229	220,384
	141,091	163,722	191,575
	65,795	126,106	188,272
	48,593	114,236	167,014
	46,593	109,414	112,819
	42,902	99,351	108,786
	4,853	69,990	104,642
	2,966	46,238	80,561
		36,717	67,994

Minnesota	1979	1980	1981
	$121,295	$115,771	$108,744
	104,416	56,006	65,290
	75,072	33,713	41,370
	46,320	19,565	26,850
	37,336	19,470	17,771
	32,234	19,145	13,089
	27,181		
	21,240		
	20,920		
	19,469		

Ohio	1979	1980	1981
		$212,404	$386,890
		97,670	164,948
		70,509	150,498
		57,703	123,161
		42,495	112,909
		34,205	54,015
		24,257	50,610
		23,887	42,582
		7,168	25,367
		7,104	19,659

Figures shown for 1980 reflect 10/1/79-3/31/80 (first half fiscal year 1980). Figures shown for 1981 reflect 4/1/80-3/31/81 (last half fiscal year 1980 and first half fiscal year 1981).

Wisconsin	1979	1980	1981
	$46,872	$34,283	
	41,907	30,610	
	37,385	29,455	
	33,775	23,245	
	32,232	20,911	
	22,780	17,470	
	22,451	13,329	
	15,015	13,014	
	13,747	10,509	
	13,487	10,280	

Region VI—Dallas

State

Arkansas	1979	1980	1981
	$107,090	$47,110	$54,584
	50,335	45,901	30,138
	36,495	24,947	23,168
	27,564	22,075	22,847
	20,488	21,846	20,140
	20,293	21,304	19,700
	18,490	20,482	19,500
	18,430	19,932	19,325
	17,895	18,574	19,011
	17,360	17,013	18,939

Louisiana	1979	1980	1981
			$207,227
			73,074
			68,591
			56,910
			48,778
			44,995
			37,485
			37,430
			28,448
			24,990

Figures represent period 7/1/80-6/30/81

New Mexico	1979	1980	1981
			$11,513
			9,290
			7,355
			6,991
			6,084
			5,573
			4,714
			4,664
			4,500
			4,148

Figures above for the period 1/81-6/81

Oklahoma	1979	1980	1981
		$70,598	
		57,165	
		34,037	
		29,925	
		29,625	
		27,837	
		23,797	
		23,793	
		22,847	
		22,209	

Figures shown for the period 1/1/80-12/31/80

Texas	1979	1980	1981
	$114,567	$234,141	$481,789
	94,564	135,242	196,856
	69,129	103,808	66,422
	65,181	47,762	58,109
	46,113	46,786	56,230
	40,790	41,356	40,981
	39,721	37,190	36,606
	32,364	34,630	35,487
	30,823	32,376	33,914
	30,800	32,157	32,940

Region VII--Kansas City

State

Iowa

1979	1980	1981
$62,093	$133,729	$119,802
51,492	45,948	36,249
39,271	39,125	28,801
24,975	32,922	20,455
18,358	10,693	15,651
16,029	17,680	15,651
11,280	16,535	9,674
10,564	12,699	9,024
9,282	11,520	7,966
5,998	10,693	6,375

Figures shown for calendar year

Kansas

1979	1980	1981
$23,977	$56,769	$86,539
21,044	25,497	29,348
12,541	21,396	27,917
10,543	16,808	27,669
9,766	11,783	22,970
9,313	11,293	15,915
9,026	10,152	11,257
8,327	8,467	11,105
7,001	7,511	9,909
6,648	7,306	8,806
	6,239	7,924

Missouri

1979	1980	1981
$101,612	$121,711	$71,804
74,110	104,258	50,150
73,102	89,572	48,640
54,082	87,735	45,640
51,510	79,842	44,715
48,897	70,252	37,156
38,811	51,148	36,554
33,171	42,965	35,549
32,612	42,827	28,066
25,878	39,390	27,043

Nebraska

1979	1980	1981
$81,225	$162,030	$62,930
19,590	25,413	20,023
19,071	22,437	19,011
15,143	12,700	17,318
10,851	11,652	11,733
10,767	11,617	11,550
7,803	10,151	10,987
6,985	9,484	10,079
6,909	8,807	9,402
6,535	7,485	8,827

Region VIII—Denver

State

Colorado

1979	1980	1981
	$14,248	$ 9,988
	10,692	5,679
	8,532	5,336
	6,118	5,223
	5,925	4,484
	5,796	3,725
	5,522	3,702
	5,298	3,380
	5,206	3,287
	5,168	3,250

Montana

1979	1980	1981
	$13,400	
	13,058	
	6,483	
	5,729	
	5,629	
	4,355	
	4,255	
	4,130	
	3,380	
	2,046	

North Dakota	1979	1980	1981
			$13,360
			9,487
			7,835
			6,075
			5,059
			3,755
			2,183
			787
			595
			297

South Dakota	1979	1980	1981
	$10,220	$17,400	$14,500
	9,570	8,840	9,500
	5,460	8,700	6,450
	2,900	4,200	6,360
		4,180	4,300
		2,520	3,150
			2,405
			1,800

Utah	1979	1980	1981
	$6,576	$11,134	$20,934
	5,585	8,096	13,514
	4,194	7,271	11,261
	3,053	5,502	8,752
	2,231	2,978	6,900
	1,928	2,842	6,221
	1,766	2,724	6,113
	1,498	2,647	5,073
	1,488	2,464	4,702
	1,439	2,415	4,449
	1,424	2,356	4,326
	1,276	2,160	4,272

Wyoming	1979	1980	1981

Region IX--San Francisco

State

Arizona	1979	1980	1981
		$59,144	$49,750
		46,723	49,607
		40,843	39,153
		34,036	32,747
		27,959	24,613
		23,766	21,758
		20,804	20,966
		20,640	20,384
		20,510	19,274
		19,357	18,219

California	1979	1980	1981
		$189,983	$532,787
		168,715	270,265
		167,788	251,301
		75,264	236,453
		66,176	213,842
		64,966	205,219
		63,927	150,086
		56,777	139,701
		54,350	130,615
		50,810	126,831

Hawaii	1979	1980	1981

Nevada	1979	1980	1981
	$14,528	$13,553	$13,167
	8,368	10,737	12,557
	8,142	6,607	12,425
	7,983	5,299	12,414
	6,215	5,207	12,133
	5,310	4,781	10,066
	4,550	4,060	8,517
	4,200	3,420	7,008
	3,811	3,345	5,908
	3,525	3,080	3,767

Region X--Seattle

State

Alaska

1979-1981
$118,758
68,421
60,202
45,984
23,658
22,209
21,429
13,732
10,959
9,298

Figures represent the period 1/1/79-6/30/81 and includes VR expenditures (approx. 1/3)

Idaho

1979	1980	1981
$7,779	$10,801	$5,394
6,390	9,558	5,265
5,286	8,892	4,593
4,587	7,350	4,185
4,488	7,235	4,030
4,360	7,141	3,793
4,351	6,775	3,022
4,062	6,445	2,720
4,054	5,772	1,915
3,830	3,398	

Oregon

1979	1980	1981
$13,642	$90,462	
10,292	20,415	
10,077	14,921	
9,700	14,602	
8,758	12,180	
8,698	10,865	
8,456	10,385	
8,325	9,579	
8,259	9,025	
7,999	8,791	

Above figures are for calendar years

Washington	1979	1980	1981
			$93,741
			75,403
			69,351
			49,035
			48,390
			47,534
			31,482
			24,660
			24,416
			21,665

The above figures represent the period 1/78-7/81

Top Ten Providers
(Supplement to Attachment C)

Thurman and Thurman

		Year	
State	1979	1980	1981
Virginia	N/A	$186,098	N/A
Kentucky	$113,000	57,000	N/A
Tennessee	727,446	804,488	N/S
Illinois	N/S	55,044	$ 75,473
Indiana	132,206	167,700	187,155

Johnson and Byers

		Year	
State	1979	1980	1981
Pennsylvania	$168,000	$642,000	$476,000
Virginia	N/A	76,713	N/A
West Virginia	40,169	283,874	235,330
Indiana	149,278	367,644	358,850
Michigan	4,853	252,229	220,384

N/A - Data unavailable
N/S - Not shown on top 10 list

Question 4: Reported Agency Procedures for Reviewing Quality and Performance of CE Providers

Attachment D

			Review of Adequacy of Reports					Review of Timeliness of Service	Review of Claimant Satisfaction	Review of Billings
			M.D.	Sup/Spec	D.E.	Routine	Special			
UNITED STATES										
Boston	Connecticut		CMC	X	X	X	X			
	Maine		CMC	X	X	X	X			
	Massachusetts		CMC				X			
	New Hampshire		X			X				
	Rhode Island		X	X	X	X	X			
	Vermont		X		X	X				
New York	New Jersey		X	QA	X	X	X			
	New York		X	QA	X	X	X	X		
	Puerto Rico		X	QA	X	X	X			
Philadelphia	Delaware		X	X	X	X		X		
	District of Columbia		X	QA						
	Maryland		X	X	X	X				
	Pennsylvania			X	X	X	X	X		
	Virginia		X	X	X	X				
	West Virginia		X	X	X	No formal process				
Atlanta	Alabama			X	X		X	X		
	Florida			X		X	X			
	Georgia		X	X			X			
	Kentucky				X	X	X			
	Mississippi		X	X	X	X				
	North Carolina		X	X	X	X	X			
	South Carolina	VR	X	X			X			
		Blind		No Report						
	Tennessee			X	X	X			X	
Chicago	Illinois		X	X		X	X			
	Indiana		X	X	X	X	X			
	Michigan		X	X	X	X	X			
	Minnesota			X		X	X			
	Ohio		X	X	X	X	X	X		
	Wisconsin			X	X		X			
Dallas	Arkansas		No systematic review--coincidental to the adjudicative process							
	Louisiana		X	X	X	X	X			
	New Mexico		X	X				X		
	Oklahoma			X		X	X			
	Texas		CMC	Not Described			X	X		
Kansas City	Iowa		X				X			
	Kansas		X	X			X			
	Missouri		X	X	X	X				
	Nebraska						X			X
Denver	Colorado		X	X	X	X				
	Montana		X	X	X			X		
	North Dakota				X			X		
	South Dakota			X			X			
	Utah		X	X		X				
	Wyoming		No Special Procedures							
San Francisco	Arizona			NA		X		X		
	California		X	X		X				
	Guam			No Report						
	Hawaii		X				NA	X		
	Nevada		X		X	X				
Seattle	Alaska			X	X			X		X
	Idaho		X	X	X	X	X			
	Oregon		X	X		X		X		
	Washington		X	X	X	X				X

Form SSA-2684 (7-78) (Formerly CO-1770) (Destroy prior editions)

MD--DDS physician
Sup--Supervisor
Spec--Specialist
D.E.--Disability Examiner
CMC--Chief Medical Consultant
QA--Quality Assurance
NA--Not Available

Attachment E

Question 3: Reported Agency Procedures for Handling Complaints

UNITED STATES		Contacts With Claimant	Contacts With Source	Administrator Handling	Second Examination	Number 80-81 Complaints
Boston	Connecticut	Unclear	X			6
	Maine	X	X			NA
	Massachusetts	X	X			11
	New Hampshire	X	X			NA
	Rhode Island	PRO	CMC			NA
	Vermont			X or CMC		NA
New York	New Jersey	X	PRO or CMC			11
	New York	X	"			94
	Puerto Rico	X	"			26 +/-
Philadelphia	Delaware			X		NA
	District of Columbia			X		NA
	Maryland		MRO			5
	Pennsylvania	X	MRS or MD			14
	Virginia	X	MRD or CMC			NA
	West Virginia			X		NA
Atlanta	Alabama	X	X	X/CMA		NA
	Florida	X	PRO AND MD			NA
	Georgia		MC Visit			NA
	Kentucky	X	X			NA
	Mississippi		X			NA
	North Carolina		X			NA
	South Carolina VR		CMC			NA
	South Carolina Blind		No Report			
	Tennessee	X	X			29
Chicago	Illinois	X	X			NA
	Indiana	X	X			NA
	Michigan	X	X			NA
	Minnesota	Not Specified				0
	Ohio		X			NA
	Wisconsin		CMC			NA
Dallas	Arkansas	X	X			NA
	Louisiana	Not Specified				NA
	New Mexico		X			NA
	Oklahoma	Not Specified				NA
	Texas		X			NA
Kansas City	Iowa	Not Specified				2
	Kansas	MRO	MRO			NA
	Missouri	X	X	X		NA
	Nebraska			X		NA
Denver	Colorado	X	CMC			NA
	Montana		NA			2
	North Dakota		NA			NA
	South Dakota		NA			NA
	Utah		NA			NA
	Wyoming		NA		Alt. Arrang.	NA
San Francisco	Arizona		X			NA
	California	Not Specified				NA
	Guam		No Report			
	Hawaii	Line Supervisor			X	NA
	Nevada	X	X		X	NA
Seattle	Alaska	Not Specified				NONE
	Idaho		MRD			NA
	Oregon		NA			NA
	Washington		MRO			

Form SSA-3004 (7-76) (Formerly CO-1770) (Destroy prior editions)

PRO--Professional Relations Officer
CMC--Chief Medical Consultant
MRS--Medical Relations Supervisor
MRD--Medical Resources Developer

CMA--Chief Medical Advisor
MD--Medical Doctor
MC--Medical Consultant
MRO--Medical Relations Officer
NA--Not Available

SOCIAL SECURITY SUBCOMMITTEE

OASDI DISABILITY INSURANCE
Definition - Medical Standards
and
✓HEARING ON VOLUME PROVIDERS
September 18, 1981

September 29, 1981

Honorable John Svahn
Commissioner of Social Security
HHH Building, 200 Independence Ave., SW
Room 613-D
Washington, D. C. 20201

Dear Commissioner:

Enclosed, herewith, are the supplemental questions from Members of the Oversight and Social Security Subcommittees as a follow up to our hearing on Septmeber 18, 1981 on volume providers of medical examinations for disability insurance claims under the Social Security Disability program.

It is our hope that you will review this hearing record personally inasmuch as you were not able to be present. The prepared testimony and the answers to the questions of the Subcommittee Members indicated that the Social Security Administration is not actively pursuing this area.

Also, I had asked in my letter of August 14, 1981, that you give us the information you were obtaining through your regional staff as to the States' use of volume providers. On September 4th you wrote in answer that the information "remains incomplete because of manual record keeping in many States" and that you would provide us the information when it was completed. No further information was offered in the hearing by the Social Security Administration. In examining the two state witnesses, however, they indicated they had provided the information to you before August 4. I hope, therefore, that this information can be provided to the Subcommittee in the immediate future.

I also asked in my August 14 letter what was the current relationship of Dr. Richard P. Lipman to the disability program. You stated in your September 4 letter that you had not completed your "investigation of Dr. Lipman nor of Johnson and Byers" but you would also transmit this information as soon as it was completed. At the hearing on the 18th the SSA witnesses were not able to give any further information in this area. I still would appreciate an answer to this question at the earliest possible time.

With best regards, I am

Sincerely,

J. J. Pickle, Chairman
Social Security Subcommittee

Enc.

JJP/gc

Follow-up questions in connection with Joint Oversight/Social Security Subcommittee hearing on volume providers of medical examinations for disability insurance claims under the Social Security Disability program, held on September 18, 1981.

1. Mr. Crank stated at the hearing that Social Security did not have information as to whether cases which contained medical reports from "volume providers" had a higher or lower denial rate than cases from other providers of consultative examinations. Could we possibly get this information on some type of sample basis or information already provided by the states? If this information indicates a higher denial rate, how would you explain this phenonomen? Do you have any information on a national basis as to the number of complaints received on volume providers as compared with other consultative physicians?

2. Both of the States which testified before our Subcommittees complained about the problem of inadequate fee schedules for consultative examinations. Pennsylvania's fees have not been changed since 1974 and Tennessee since 1978. Should SSA establish these schedules for such examinations or continue to leave this decision to the States? What would be the advantages or disadvantages of SSA setting such examintion rates?

3. At the hearing, Congressman Bailey asked about your inquiry to the states which was dated July 27, 1981, about volume providers. How many states met the August 3rd deadline you imposed? List the states that did not meet the deadline and the date on which they actually did submit their answers.

4. In your report which resulted in the reinstitution of Thurman and Thurman it appears you consulted extensively with the state agencies, but very little with the legal aid attorneys who brought the charges. They feel that they were not consulted. Why did you not question them more on what evidence they had to support the allegation?

5. Mr. Crank stated on page 8 of his testimony that "we have not had a disciplined process that permits us to obtain continuing information on the effectiveness of the states management of their consultative examination process." Describe the process you do have in a little more detail. Did this process give you enough information to make an informed decision on the initial suspension of Thurman and Thurman?

6. Mr. Crank stated on page 11 of his printed statement that his staff recently visited the American Medical Association to get some ideas on how to get quality examinations from volume providers. Specifically when did your staff check with the AMA? Was it before or after the Tennessee situation had been brought to your attention?

Mr. **Pickle**. I will recognize other members, but let me ask you first and then I will briefly come back for some additional questions.

Mr. Crank, on page 6, you said "our review of the Tennessee based Suburban Internal Medicine Group, SIMG, owned by Drs. Stephen and Grafton * * *" When you say, "our review," did your Department review it?

Mr. **Crank**. Yes.

Mr. **Pickle**. It was you, or your Department?

Mr. **Crank**. It was the Social Security Administration, and more specifically, it was done under the auspices of my colleague here with me, Mr. Schutzman.

I think Mr. Schutzman is prepared to answer questions about the nature of that investigation.

Mr. **Pickle**. I wanted to know who was doing it. Backing up for just a minute, earlier this year, in May, we understand that you had comments on the proposed State-Federal regulations that you should have a quality assurance system for consultative examinations. You replied to those comments, "We do not believe the performance of consulting physicians requires regulation by us." That was in May of this year.

Today, 4 months later, you state on page 11,

> We will monitor the adequacy of State consultative examination practices to ensure that integrity is being maintained. We will see that quality assurance includes evaluation of the quality of consultative medical reports.

It seems to me like you have said in the one instance, we do not believe that the performance of consulting physicians requires regulation by us. And now you are saying we are going to take very strong steps, and you outline about five different steps you can take.

Does this indicate a change of attitude on the part of SSA?

Mr. **Crank**. I think not, Chairman Pickle. I don't want to play word games, but I think we see a distinction between regulating the conduct of consultative examinations by physicians and providing the program requirements in terms of oversight or what we expect State agencies to do.

What we were saying in May is that we don't think we need to regulate directly how doctors perform consultative examinations. We are in the business of purchasing a professional service from a licensed medical practitioner, and there are regulatory bodies that are in the business of regulating those physicians and their practices.

We are also saying that, although we are purchasing a professional service, we want that service to meet certain program requirements, and those requirements we are setting forth now.

Mr. **Pickle**. Mr. Crank, I want to go back, I am not going to argue with you. You say on the one hand you don't believe that consultative examinations require regulation by you. Clearly, that is your position.

Now you are saying that you do want consultative examinations to be regulated. Now do you or don't you?

Mr. **Crank**. Are you asking—do we want consultative examinations?

Mr. **Pickle**. Yes. And regulation by your agency.

Mr. Crank. We can't operate this program without consultative examinations.

Mr. Pickle. Then this is a change of position. I hope it is a change of position. You are saying it is not?

Mr. Crank. I don't see it as a change of position.

Mr. Pickle. What has been your attitude. Do you believe that the States should use volume providers? Have you encouraged that or discouraged it?

Mr. Crank. We believe we have encouraged it. We have encouraged States to make arrangements——

Mr. Pickle. What is the attitude, then, of the Social Security Administration with respect to the use of the Thurman and Thurman volume providers in Tennessee? Did you approve that? Do you have a position on it?

Mr. Crank. Did we approve it in advance?

Mr. Pickle. Yes, sir.

Mr. Crank. No, we do not now have a process and don't anticipate having a process whereby we give specific advance approval on the use of a particular consulting source.

Mr. Pickle. Did the regional office in Tennessee approve this consultative examination process of using volume providers?

Mr. Crank. In advance of the State using that source, I suspect not. But I cannot answer that question directly.

Mr. Pickle. Either in advance or when it became known.

Mr. Crank. As I indicated in my testimony, once the Judge's characterization of Thurman and Thurman as fraudulent came to light, the Social Security Administration central office stepped in and suspended use of Thurman and Thurman.

So there was no role for the regional office to play at that point.

Mr. Pickle. I want to say that I understand that the regional office down there were concerned about it and sent word to you that this was not a proper procedure and warned against it. And that they had no response from your agency.

Mr. Crank. May I consult for a moment, Mr. Chairman?

[Pause.]

Mr. Crank. Mr. Chairman, I am not personally, nor is Ms. Greenberg, personally aware of any such referral from the regional office, but I will look at that.

Mr. Pickle. I think it will warrant it. There were so many of these volume provider cases coming in that they warned the agency that it ought to be alerted to some possible misuse or overuse of the procedure.

You stated that your medical staff also reviewed a number of the Thurman and Thurman reports and found them sufficiently detailed with respect to the evaluation the State DDS had requested.

Presumably these included the machine-generated reports from the Kingston, Tenn., area which was under scrutiny. What does your medical staff think of a practice of a physician doing 25 to 35 examinations and reports in 1 day? Does this seem reasonable?

Mr. Crank. Our medical staff looked at those reports from the standpoint of how they fit with other evidence in the file, and how they comport with other evidence from other treating sources in the file.

They didn't look at this from the standpoint of can you do *x* numbers of examinations in a day. They looked at each report from the standpoint of could they make reliable professional judgments about the validity of that information from the evidence available in the file.

Their conclusion——

Mr. PICKLE. Let's just assume you had 25 or 30 examinations, and I didn't mean to cut you off, but that would mean that a physician would then be able to give no more than about 10 to 15 minutes on a case if he's going to get out 25 or 30 a day.

Now I go in to have a medical examination here at the Capitol. They run me through quickly, but it takes an hour, at least. How can the providers turn out as many as 25 and 30 a day and give quality examinations? Do you think that is possible?

Mr. CRANK. I think it depends in part, Mr. Chairman, on how many other people are helping that physician get information about that individual. The use of paramedical professionals in helping physicians do examinations and obtain information about people, such things as histories, the taking of preliminary tests, blood pressure readings and the like, is a well-accepted practice in the medical community.

So I think when you ask the question, can a physician see *x* number of people in a given day and give quality service, I think that question, or the answer to it, has to include how many people are helping that physician and what are the qualifications of those people.

Mr. PICKLE. If a physician looks at a man and says, do you have a bad cold or not, I don't think it would take an hour to determine that.

But if you are going to determine whether a man is or is not disabled, that is an entirely different type of examination. I don't care whether you have one or six people helping.

It seems like that ought to be somewhat suspect. Your answer to me is that your agency did go down there and review each one of these cases of Thurman and Thurman and found there was no volume practice and that the examination had quality character to it?

Mr. CRANK. We didn't reach a specific conclusion on the volume issue. What our medical staff reached its conclusion on was individual cases. Recognizing that we were dealing with a paper review, their conclusions were that the information in the Thurman and Thurman reports was comprehensive, it addressed the issues, and it was consistent with the claimant's allegations and history.

The conclusion of the professional physicians on our medical staff was that those reports were as good as others we received from practicing physicians.

Mr. PICKLE. Mr. Bailey.

Mr. BAILEY. Thank you, Mr. Chairman.

Mr. Crank, do you have any information at all comparing the approval or disallowal percentage to claims between volume providers as opposed to any other type of provider?

Mr. CRANK. No, we do not have that kind of data discrimination in our records to date, Mr. Bailey.

Mr. BAILEY. Is that a decent question?

Mr. CRANK. I think I know what issue your question presupposes, but the consulting physician does not make the determination of whether the person is or is not disabled.

Mr. BAILEY. No, he doesn't make the determination. But you know darn well what happens with a 2- or 3-minute checkout of someone. At least the information we have indicates that what was given to the determining official, even in some cases before, you know, the claim is adjudicated before we even got to the ALJ, in some cases were very voluminous, computer-composed printouts.

These are allegations that have been made. I don't know. I haven't seen them. But that is a little silly. You can't say that if your data base isn't good.

Mr. CRANK. Let me expand on the answer.

Mr. BAILEY. Please do.

Mr. CRANK. You asked do we have information that shows difference in allowance and denial rates between volume——

Mr. BAILEY. Did you ever ask the question?

Mr. CRANK. No, we have not collected that information. I have asked the question recently and we don't have the information.

Mr. BAILEY. How long ago did you ask the question?

Mr. CRANK. In the month of August.

Mr. BAILEY. When in August? Who did you ask? Where did you go?

Mr. CRANK. I asked people who collect data in the Social Security Administration.

Mr. BAILEY. The committee request came to you in an August 14 letter from Chairman Pickle. When did you ask the question, before that?

Mr. CRANK. Yes, I had asked it internally before that, and found we don't have that kind of information in our records.

Let me, if I may, proceed with the answer.

Mr. BAILEY. Yes.

Mr. CRANK. We have known for a number of years in the disability program that the incidence of denials increases the more you get consultative examinations.

Mr. BAILEY. Give us those percentages, please.

Mr. CRANK. I would like to then give you those for the record.

Mr. BAILEY. Will you get them for us as soon as you can?

Mr. CRANK. We will furnish those.

[The information follows:]

INITIAL SOCIAL SECURITY DISABILITY DETERMINATIONS: DENIAL RATES AND CONSULTATIVE EXAMINATION RATES

	Denial rate	Consultative examination rate
Through 3d quarter, fiscal year 1981	66.2	37.4
Fiscal year:		
1980	64.5	34.6
1979	61.9	33.2
1978	59.0	31.3
1977	54.8	28.0
1976	52.2	23.4

Mr. **Bailey**. The disallowed percentage increases with the degree of consultative exams?

Mr. **Crank**. That's right.

Mr. **Bailey**. But you don't have a breakdown of any relationship between volume providers allow or disallow rates on claims, and other types of consultative examination providers. But you have asked that question?

Mr. **Crank**. I asked do we have any information that would shed any light on that and the answer was no.

Mr. **Bailey**. Who would you go to for that information?

Mr. **Crank**. Who would we go to? We would have to go to the States ultimately for that information. We would have to define a volume provider. Ever since we began the discussions earlier this year, we have not had a definition of a volume provider——

Mr. **Bailey**. Have you tried to secure a definition of a volume provider?

Mr. **Crank**. We, I think, will define volume provider as we get further down the process of providing additional guidance to the States.

Mr. **Bailey**. I want to read something to you and I want you to help me with some of the acronyms, OK, because I think you have been asking these questions and you were supposed to have had this information in.

It goes directly back to what Chairman Rangel asked you. This is from the "Social Security Administration, Office of Operational Policy and Procedures, Baltimore, Maryland. To all Social Security Regional Commissioners." Nothing particularly damaging about this, but it shows you were asking questions a long time ago, and what you haven't done, it appears, is follow up or try to get this information together, either for this committee or in the face of what you knew were some very serious questions and allegations.

And I read:

> Subject. Medical consultative examinations. A U.S. district court in Virginia has expressed grave concern about the practices of a group medical practice which performs a large number of consultative examinations for the DDS's in Virginia and several other States.
>
> This concern has been repeated in a great deal of press coverage. In view of this, we need to have a clear understanding of the management and oversight of all DDS's, CE-source operations.

What does that mean for the sake of the record?

Mr. **Crank**. All sources, clinics, hospitals, practicing physicians who provide consultative——

Mr. **Bailey**. This gets better. It shows what was in your mind at the time. I assume somebody here was aware of this, or you were, or someone, I would hope, very high up in your administration, your office.

Mr. **Rangel**. What is the date?

Mr. **Bailey**. I have a July 27 date on it, but the interesting thing, Chairman Rangel, is that the request to have the information into this Office of Operational Policy is for August 3.

> Accordingly, we are asking that you confer with the DDSs in your region to obtain the following preliminary information. Describe the CE panel to include numbers and types of providers as well as any special arrangements such as block time allotments or bulk provider agreements used.
>
> Describe the process used in selecting the CE source to be used in each case. For fiscal year 1979, 1980 and 1981 to date, provide the following information: How

many CE sources, that is, separate billing entities, were used by each State. What was the range of payments to those sources in dollars.

Include specifics with respect to the top 10. For those billing entities that include more than one physician, specify the number of physicians involved. Describe agency procedures for reviewing the quality and performance of CE providers.

Describe agency procedure for handling complaints received about CE providers. Include a summary of complaints received in 1980 and 1981.

Provide sample forms or check sheets used in any of the above quality control procedures, as well as any statistical data.

That is very general.

"On the above, which may be helpful."

Page 3: "If your office has conducted a DDS review in 1981, EGAFMAR," I don't know what that is, "in which this information was obtained, you may use a copy of the report of that review to respond to this request."

That shows quite a history of awareness.

"Please compile all the data for your region and send it to me by Monday, August 3, 1981."

You were directly aware of the court case. You mentioned it here. That is why I asked the question, you have either compiled data or why you can't have done more.

You hear your responses to Chairman Rangel's questions and it just doesn't square with your subjective knowledge.

Here is evidence of what was going on and what your questions were.

Mr. **Crank**. At the top of page 8 of my testimony, I indicated the States are now providing us with that information. It is that information requested in that communication they are now providing. We did ask for that by August 3.

Many States were not able to meet the August 3 deadline. We have preliminary information, but we certainly don't have complete information on all of those.

I think, Mr. Bailey, you will see in that that we do not define volume providers.

Mr. **Bailey**. Let me ask one last question because we have to move along. The Federal Government pays the costs of the benefits, is that right?

Mr. **Crank**. That's right.

Mr. **Bailey**. The Federal Government pays the cost of the examination?

Mr. **Crank**. That's right.

Mr. **Bailey**. Without your encouragement, without your management, what incentive is there for a State, especially in light of the current President's policies, to do this without your guidance and encouragement?

Mr. **Crank**. There is no incentive outside of what we recommend in the Social Security Administration and States see as their responsibility.

We produce that incentive in a variety of ways. We have established outcome standards for the States in terms of accuracy of decisions and processing time.

We have provided them with funds. But your point, I think, is that the State has no incentive, other than what we provide. I think you are substantially correct.

Mr. **Bailey**. I don't see how you can expect the kids to do it if daddy doesn't look after the shop first. It doesn't make sense to me.

I yield back, thank you, Mr. Chairman.

Mr. **Pickle**. Thank you for yielding back.

Mr. **Guarini**. I must say you really haven't been responsive. Your homework isn't as I would like to see it. You have the responsibility of looking after the public trust.

They do regulate themselves, that may be true. Let me give you an illustration of a familiar matter I had. I had a mother who went into a hospital for a checkup not long ago and got a bill from a doctor for $275 and she never saw the doctor.

I called him up and he said, well, "the Government is going to pay for it. What do you care about it?" I said, "I do care about it. You didn't see her." He said, "well, I went down, read the records in the hospital room. Gave my professional opinion. I am a neurologist and, therefore, I am entitled to $275."

If that is the quality and control of that hospital or that particular doctor, don't you think it would be your responsibility to look into it a little deeper and not just leave it to the medical profession to supervise themselves?

Mr. **Crank**. Yes, particularly if I were the administrator of the medicare and medicaid programs.

Mr. **Guarini**. Therefore, I think you do have a responsibility to regulate the quality control, regardless of the fact that doctors regulate themselves and lawyers regulate themselves.

Let me ask you, what is the average cost of each examination?

Mr. **Crank**. The——

Mr. **Guarini**. I understand it cost the Government in 1980, $84 million for the examinations of 712,000 people. That is $125 per examination.

I understand in 1982, that the figure is $145 million, 3 years later, almost twice as much.

Now, I don't know how many exams that is for, but it can't be for that many more than the 712,000. If that is so, that is a $200-an-examination cost.

Could you clarify that for me, please?

Mr. **Crank**. Yes. Our estimates of cost for fiscal year 1981 and the number of examinations is that there will be approximately 951,000 examinations done at an average case cost of $144.45.

Mr. **Guarini**. $144.45. Now you say in some cases, there are doctors that do 25 and 30 cases a day that they sign reports of. If that is so, that means that a doctor can make over $4,000 a day by having a factory examination setup, is that so?

Mr. **Crank**. Your mathematics are correct.

Mr. **Guarini**. I think that is deplorable. I think the public's entitled to a better shake than that. If that is so, and if you don't look into it, I think you are irresponsible in your job, sir.

No further questions.

Mr. **Pickle**. Thank you, Mr. Guarini.

Mr. Crank, I hope you can stay, if you can, because we have two other witnesses, and we may want to ask you questions later as we go along here. Earlier this year, you had stated that States set medical exam rates which were generally adequate to assure the participation of competent professional personnel.

I am wondering, can you document this, and whether you think that the rate which was set is adequate?

Is this not a fact that inadequate fees can cause the development of some of these—the volume provider practices?

Mr. **CRANK**. Yes, Mr. Pickle. I don't recall saying that I thought the fees States are paying are adequate.

What I said is that we intend to continue to allow the States to set the fees. In looking at State fee schedules, we find that generally they are set by States or State programs and are generally reflective of a high degree of fiscal conservatism in many States. In some cases, that works to the detriment of the disability program.

Mr. **PICKLE**. When you made your statement, you made it when you set the regulations. The question that comes to my mind now is, are the examination fees adequate in the two States we are going to hear witnesses from in just a minute? Are they adequate there?

Mr. **CRANK**. May I ask my colleague?

[Pause.]

Mr. **CRANK**. I don't have information here with me today, Mr. Pickle, on fees in those particular States. Maybe the State witnesses can give you that answer better than I can.

Mr. **PICKLE**. One last question. On page 11, you state that you have recently visited the AMA to get their views on this matter. The social security program used to have an advisory board on medical matters, including AMA membership. But this was abolished some 10 years ago.

This subcommittee has got a bill relevant to these issues—H.R. 3207. One section of the bill would reestablish this board on a statutory basis with the primary function of examining and giving expert advice on subjects such as this.

The bill would also authorize moneys for continuing education for consulting physicians. Is this something that we should do legislatively; is this something we should include in the bill?

Do you have an opinion on that? Should we reestablish the board so we can get direct recommendations from physicians such as the AMA?

Mr. **CRANK**. For the purposes of helping us in the interest of the program?

Mr. **PICKLE**. Yes.

Mr. **CRANK**. Certainly if you established such a board, we would use it and we would try to use it very effectively.

Mr. **PICKLE**. I am asking do you think we should do this?

Mr. **CRANK**. We believe we can get very competent professional advice without creating a board and all of the——

Mr. **PICKLE**. All right. Is it your testimony as a representative of the SSA, that you don't think we ought to have an advisory board on medical matters?

Mr. **CRANK**. I am not——

Mr. **PICKLE**. That is what you said.

Mr. **CRANK**. I am giving you my professional opinion on that as an Associate Commissioner. It is a question I have specifically not——

Mr. **PICKLE**. You are saying you don't think you need it and you'd just as soon not have it. You don't recommend it, in other words. You recommend against it?

Mr. **Crank**. I don't——

Mr. **Pickle**. Is that SSA's position?

Mr. **Crank**. No, that is not SSA's position, because I have not discussed that with the Commissioner.

Mr. **Pickle**. I suggest you discuss that.

Mr. **Crank**. If you want an SSA position, we will give it to you on that position.

[The information follows:]

Although we believe that consultations with the medical community on disability evaluation policies and other matters are extremely important, we think they can be handled responsibly and beneficially on an ad hoc basis, and therefore do not favor legislation that would establish a Medical Advisory board.

As Chairman Pickle noted, a Medical Advisory Committee (MAC) was established and functioned in the early years of the disability program. That committee served a vital function in the area of helping to gain acceptance of the Social Security disability program in the medical community. Once that objective was accomplished, and the program's medical criteria—the listing of impairments—were developed, MAC served a less useful purpose. In fact, administrative costs and staff support to continue the MAC were eventually out of line with the MAC's ongoing program contribution.

Mr. **Pickle**. You already have the American Medical Association as your advisors in this matter, right?

Mr. **Crank**. We went to the American Medical Association for two purposes. We wanted to ask the American Medical Association, if the medical profession itself had any standards of performance relating to the provision of consulting services and independent medical examinations.

Mr. **Rangel**. And they told you, no.

Mr. **Crank**. They, in essence, told us, no.

Mr. **Rangel**. And you knew they didn't have any standards as relates to governing group practices or anything, right?

Mr. **Crank**. Our next question was, would the AMA be willing to work with us in setting up performance standards?

Mr. **Rangel**. And they said, yes.

Mr. **Crank**. No, their recommendation was not to work directly with them, but to go to other more local organizations, including specialty associations such as the American Society for Internal Medicine.

Mr. **Rangel**. If the chairman would yield further, because I don't want our Government embarrassed any further. Either we have got to block grant this program and just get out of it completely, which maybe the President would want us to do. Or we have to protect the Federal funds that are in the trust fund.

We just can't turn it over to a group of doctors who, in their own self-interest, are not going to critique us as to how many cases they can handle.

That is like putting a cap on their income, which doesn't make a lot of sense to me to ask for guidance as to what they can do.

They would be violating their own tenets, as well as State law, if they accepted fees for an incompetent job. Right? Right. So why don't you help us to help the Social Security Administration in making certain that the States and the doctors provide you with some answers, because we are going to have to have additional hearings.

When do you think we should schedule the hearings so that you would have this information, because it is clear you don't have it today.

Mr. CRANK. We would, based on your questions and the kind of information I think you really need and we need, I would say hearings scheduled any time after a month from now would be much more timely, Mr. Rangel.

Mr. RANGEL. Thank you for your patience, Mr. Chairman.

Mr. PICKLE. Thank you. Our committees will participate jointly in further hearings. The Chair is going to thank you, Mr. Crank, for coming. We know this is a difficult area. We don't like to create a new board, we don't like to set up regulations that tend to have Federal control of these examinations.

It ought to be done by the physicians and done locally and regulated there primarily. But as Mr. Rangel said, we cannot spend over $100 million calling for consultative examinations in about 40 percent of the cases and not have some better control. We ought to look at the question closely.

A lot of the physicians probably don't want to be involved in this operation. The fees may be one reason. The possibility that they will be involved in a lawsuit is very definitely another reason.

So there are instances when we may want to go other routes. Perhaps there are instances where the volume providers serve a purpose because nobody else will provide these examinations.

That doesn't mean we have to stand back and say we are not really interested in any regulations, that we don't need to involve ourselves because it is the trust fund's money.

So this committee and the Oversight Committee are going to keep a very close check on what you are doing, to get a better understanding. We will expect to see you again in about a month. Thank you very much.

Now the Chair will call to the witness table, Mr. Herbert L. Brown, Tennessee, and Mr. George Lowe.

If both of these gentlemen will come up to the witness table.

Mr. CRANK. Mr. Chairman, I will stay in the room and I will be available.

Mr. PICKLE. Thank you, Mr. Crank.

In order that I may identify you gentlemen, which of you is Mr. Brown?

Mr. BROWN. I am Mr. Brown.

Mr. PICKLE. Mr. Brown is director of the Tennessee Disability Determination Section, Division of Vocational Rehabilitation, Tennessee Department of Education.

Mr. George Lowe is the director, Bureau of Vocational Rehabilitation, Pennsylvania Department of Labor and Industry.

I understand you have Mr. John DelPaine, assistant director of that division, with you.

I am going to suggest to the committee that we have the statement of Mr. Lowe and Mr. Brown. Then we will have questions of both you gentlemen. Is that agreeable?

We will recognize Mr. Lowe.

STATEMENT OF GEORGE LOWE, DIRECTOR, BUREAU OF VOCATIONAL REHABILITATION, PENNSYLVANIA DEPARTMENT OF LABOR AND INDUSTRY, ACCOMPANIED BY JOHN DELPAINE, ASSISTANT DIRECTOR, DISABILITY DETERMINATION DIVISION

Mr. Lowe. Thank you, Mr. Chairman. I want to thank you for the opportunity to discuss with you the use of volume providers of consultative examinations in the Federal disability program.

I brought with me a prepared text to submit for the record.

Mr. Pickle. Your entire statement will appear in the record. Please proceed, Mr. Lowe.

Mr. Lowe. I would like to spend a minute or so presenting a brief overview of the situation in Pennsylvania. After which, I would be very happy to answer any of the questions I can on my testimony.

Mr. Pickle. Fine.

Mr. Lowe. As recently appointed director of the Pennsylvania Bureau of Vocational Rehabilitation, I have been charged by Governor Dick Thornburgh to conduct an intensive review of the entire vocational rehabilitation delivery system in Pennsylvania.

Inclusive in this system is the responsibility for the administration of the Federal disability program. In Pennsylvania, we believe new directions in service delivery can be achieved to combine the need for effective management of financial resources with the need for preservation of our clients' self-dignity.

In approaching this task, I have begun to review the operation of the disability determination process as it has been administered in the past in Pennsylvania. As recently as 6 weeks ago, I became aware of some of the problems in our DDD process, specifically the use of volume providers.

I became aware of these problems from several sources. Among them, a letter from a disability claimant, as well as information from a member of the media in Pittsburgh. As a result of this information, I have initiated an investigation into the allegations to determine their validity and to determine what course of action is necessary to deal with them.

We have moved on some of these issues in the last several weeks. We have begun to develop a standard for the number of examinations that can be reasonably conducted per day, per hour.

We are now informing every claimant of their right under our system in Pennsylvania to select their own physician, providing that physician can meet SSA standards and have their right to reject a physician assigned by DDD in the conduct of an examination.

We are requiring that any facility used to examine our clients be free of architectural barriers.

Finally, we are conducting negotiations with medical schools throughout the State to provide residents to conduct examinations. We believe when these physicians are attracted into our system, we will have properly balanced our service component and minimized our necessity for the utilization of volume providers.

As this investigation continues, there will undoubtedly be additional actions necessary to improve our disability determination system in efficiency, as well as in sensitivity to the whole client community. Again, I will be happy to answer any questions I can.

If there are areas where I do not have adequate information, I will be glad to supply information to the committee at a later date. Thank you.

Mr. PICKLE. Mr. Lowe, the statement you presented, is that an additional statement over and above what testimony you have submitted to us?

Mr. LOWE. That's correct, Mr. Chairman.

Mr. PICKLE. We would like to have a copy of that, too.

[The prepared statement follows:]

STATEMENT OF GEORGE LOWE, DIRECTOR, BUREAU OF VOCATIONAL REHABILITATION, DEPARTMENT OF LABOR AND INDUSTRY, COMMONWEALTH OF PENNSYLVANIA

Thank you, Mr. Chairman, Congressman Bailey, and members of this Committee, for the opportunity to discuss with you the use of volume providers of consultative examinations in the Federal Disability Program. In addition to myself, Mr. John DelPaine, Assistant Director for our Disability Determination Division, is with me.

We share the Committee's opinion that medical examinations play a crucial role in the Federal disability determination process and that their quality and timeliness go to the heart of the fairness and solvency of the program. It was natural for us to look at the Consultative Examination (CE) process to find innovations to help us meet our goals. Volume CE's were one of the innovations. They are designed to examine numbers of disability applicants and to tailor their reports to the needs of the disability program. They offer guarantees in terms of accuracy and processing time, which are not always available from other medical sources.

Pennsylvania has been using such providers since 1978. At this time, I would like to discuss how we go about scheduling examinations for applicants and how we recruit and maintain a panel of consultants. Both these issues are central to utilization of volume providers.

SCHEDULING CONSULTATIVE EXAMINATIONS

In the course of obtaining medical evidence to document a disability claim, it may become evident that existing reports do not have sufficient information necessary to make an accurate determination. In these situations, it is necessary to purchase examinations and/or testing to complete documentation of the claim. In order to meet the Federal processing time targets of 37 days and 43 days for Title II (Disability Insurance) and Title XVI (Supplemental Security Income), respectively, this decision must be made before the 20th day of case development to allow for scheduling and completion of a report.

The decision to request a consultative examination is made by a Disability Claims Adjudicator. To ensure the appropriateness of this examination procedure, the request must be approved by a Disability Adjudication Supervisor and then by a Disability Physician. None of these approving the request may designate a particular consultant unless special circumstances exist as follows:

(1) The applicant wishes to have his own physician do the examination.

(2) The applicant does not wish to see a particular physician.

(3) There are conflicting reports in file and the opinion of a third party is needed. (A notation may be made only not to use the first two physicians).

(4) An Administrative Law Judge requests that a particular physician be used or not used.

(5) A follow-up exam is needed with a physician who has seen the claimant previously.

After the request is approved, it is forwarded to the Medical Services Unit which surveys all available specialists in the applicants geographic area and selects one using the following scale of priorities:

(1) Quality of reports.

(2) Processing time of reports.

(3) Cost.

(4) Rotation (all available consultants are offered equal opportunity to do exams when 1-3 are equal).

(5) Special circumstances.

After the selection is made, the request is completed and returned to the Disability Claims Adjudicator for processing.

The information on the request is transferred to form letters which are sent to the applicant and the consultant. The applicant receives with his letter, a pamphlet explaining the CE procedure. In Pennsylvania, one of the changes we are planning to implement is to inform claimants that they may exercise the option to reject the physician appointed by DDD or be examined by their own personal physician providing that physician meets SSA reporting requirements. We believe this will provide some claimants with a more comfortable examination atmosphere. To further assist the claimant, a toll-free number of the Disability Determination Division (DDD) and the name of the Disability Claims Adjudicator are included.

Three to five days before the scheduled appointment, the Disability Claims Adjudicator calls the claimant to confirm that he/she has received the letter and intends to keep the appointment and inquires if any special assistance is needed by the claimant.

The process of scheduling consultative examinations in Pennsylvania has been developed in a manner to guarantee effective case adjudication that is both professional and timely.

RECRUITING AND MAINTANING A PANEL OF CONSULTANTS

In 1976, the Pennsylvania DDD appointed a Medical Relations Supervisor in each of its three branch offices for the purpose of recruiting, training, and maintaining an adequate panel of medical and psychological consultants. To meet current examination needs, the panel must be sufficiently large to handle approximately 20,000 consultative examinations in each DDD branch per year.

Any physician who is licensed to practice in the State may join the panel and may remain on the panel as long as he/she demonstrates the ability to submit timely reports which contain the information required by SSA to adjudicate a disability claim. To ensure timely processing to meet Federal requirements, consultants are asked to offer appointments within ten days of our request and to deliver reports within 15 days of the examination.

Consultants are expected to accept training by the DDD Medical Relations Supervisor to familiarize themselves with SSA guidelines and standards. The medical-legal nature of our decisions require that physician reports be exceptionally detailed in discussing both the positive and negative findings. The detail is so important that we provide outlines to specialists in internal medicine, orthopedics, and psychiatry; the three most used specialties. Additionally, the consultant is expected to be available to discuss with DDD staff his/her report to add and/or clarify points on an "as needed" basis so that a final report can be achieved within a few days. This means he/she must be receptive to phone calls from DDD personnel, usually during office hours.

In Pennsylvania, to effectively monitor and supervise the DDD consultative examination process, we require the following procedures to be implemented. After initial training with the Medical Relations Supervisor, the consultant may begin to do examinations. If the consultant is a volume provider, training is offered to all the examining physicians. The first three to five reports from a new consultant are reviewed by the Medical Relations Supervisor to assess the adequacy of the training. If necessary, re-training is done. After this, the consultant's reports are reviewed annually. With a volume provider, we may review batches of reports rather than individual ones, and we review each physician in the group individually. We feel this process enhances submission of accurate examination reports by participating physicians.

Throughout the year, we have a procedure for reviewing complaints about consultants from DDD staff. Staff complaints of late or inadequate reports are submitted in writing. The complaint and its resolutions are filed in the consultant's file, which is maintained by the Medical Relations Supervisor. The DDD Medical Consultant may be asked for advice or assistance with more difficult problems. Every attempt is made to resolve the problem, and during this time the consultant will probably be temporarily removed from the scheduling rotation. If the problem cannot be solved, the consultant is permanently removed. In the rare event that a complaint is beyond the scope of DDD resolution, it can be referred to the State Bureau of Occupational and Professional Affairs, which is the medical licensing agency in Pennsylvania.

Applicant complaints are handled in a similar manner. The complaint is recorded and thoroughly investigated by the Medical Relations Supervisor. The consultant is contacted and given an opportunity to remedy the situation. The DDD Medical Consultant may be asked to review the situation and offer suggestions for resolution. Examples of types of complaints we have received in the past are: the accessibility of the office, and the amount of time spent or the thoroughness of the examination. Findings of the review, as well as final resolution of the problem, are communicated to the applicant. We are currently developing a system of examination scheduling to ensure appointments at barrier-free facilities for applicants with mobility restrictions.

Our Medical Relations Program is designed to meet the need to oversee all our medical consultants, both private practitioners and volume providers. It has been developed with the cooperation and guidance of SSA.

A late or carelessly done consultation can cause the claimant to receive a late or incorrect decision and it is our obligation to see that this does not happen.

Our objective is that medical consultants treat disability applicants with dignity and respect. In other words, we expect consultants to deal with our applicants the same way they would their private patients. At times, the Social Security Disability Program can seem to be an impersonal system. We are striving in Pennsylvania to make it more humane by a number of means, one of which is to develop guidelines for physicians to consider when conducting consultative examinations.

On the other side of this picture, the consultants complain that some disability applicants do not conduct themselves as they should. Some applicants are perceived as acting in a belligerent or hostile manner and neglect to accept their responsibility to keep appointments. This is not meant to imply that most disability applicants are uncooperative, but actions such as these can make it difficult to keep consultants on the panel.

The panel has a high turnover rate as we can usually recruit new practitioners until they become busy with private patients. On the other end of the spectrum, we can sometimes recruit the retired or semi-retired physician. We are seldom able to keep highly qualified specialists whose practices are at their peaks. The limited number of referrals accepted by these physicians makes disability claimants a very small percentage of their practices. Their reports are not always timely as their completion is dependent on the doctor's other duties which may take precedence. This has caused the program to look for alternatives such as volume providers.

Volume providers are geared to meet the purposes of the disability program. They offer consistency, guarantee timely reports, and are well-versed in our reporting requirements. They are able to do this because they are organized exclusively to conduct disability examinations. Perhaps the most significant reason is that most of them perform the ancillary medical tests in the office, whereas private practitioners send patients to hospitals and labs which leads to further delays in timely submission of reports.

WHAT HAS THE PENNSYLVANIA DDD DONE TO DEAL WITH THESE PROBLEMS

As earlier stated, our Medical Relations staff was established to recruit, train, and maintain a panel of consultants.

We have established "alternative" volume scheduling arrangements with highly respected medical schools in Philadelphia. As another initiative, we are in the process of expanding this scheduling arrangement to include other medical schools in the Commonwealth. It is anticipated that this process will achieve the timely and accurate reports as provided by other volume sources.

In another effort to attract more practitioners, we have set up small block-time scheduling arrangements. This is done by reserving a number of appointments well in advance to handle the anticipated need. To do this, however, we must first have private physicians who are willing to do these examinations.

We routinely recruit new physicians with mass mailings using Medical Society mailing lists. We contact physicians listed each month as new members of the State Medical Society in their journal. We ask present consultants to recommend colleagues and to help us recruit. Newspapers are checked for newly established practices. Adjudicators are polled for the names of new physicians they encounter in case development. County Medical Societies are asked to help us find consultants to fill particular needs.

We have initiated and expanded a telerecording system statewide. This is a toll-free line to which consultants may dictate their reports. It was primarily established to decrease processing time by getting the administrative part of the process under the program's control. It also had the effect of offsetting some of the physician's cost of doing disability examinations.

Finally, we began to consider the use of volume providers to help us to achieve the accuracy and processing time goals established by SSA. Other states had been successful with them and utilization of volume providers was recommended by SSA itself.

With continued emphasis of processing time and accuracy and the pressure of threshold performance levels for state agencies, we will continue to need alternatives such as volume providers to maintain required levels of performance. We have gained valuable experience in using them over the past few years. That experience has taught us the benefits as well as costs of utilization of volume providers.

A volume provider by the very nature of its operation; i.e., by scheduling quantities of people in a single location with multiple studies performed on-site, could give claimants the feeling they have received a less than thorough examination, especially when compared to the practices of private physicians. Claimants are accustomed to receiving consultation, diagnosis, treatment and follow-up from their doctors. They are not used to being examined solely for disability evaluation purposes. Therefore, it is incumbent on both the State Agency and the volume providers, that disability claimants be treated courteously and they receive a thorough and medically professional examination which will result in a correct disability determination.

Mr. PICKLE. Now we will ask Mr. Brown if you will make your statement.

STATEMENT OF HERBERT L. BROWN, DIRECTOR, TENNESSEE DISABILITY DETERMINATION SECTION, DIVISION OF VOCATIONAL REHABILITATION, TENNESSEE DEPARTMENT OF EDUCATION

Mr. BROWN. Thank you, Chairman Pickle.

Perhaps it's not altogether unfortunate that a Federal judge shoots from the hip and accuses a volume provider of medical reports as fraudulent. That comment is not disrespectful, but is my personal opinion of what happened.

By so doing, whether substantiated by the facts or not, the judge has brought to near national attention—perhaps you can strike the word "near"—standard operating procedures used by many, if not most, States; that being, the use of a limited number of physicians to perform the bulk of the consultative examinations needed by a State disability determination agency.

This testimony, my testimony, will deal with what occurs in Tennessee. It should not be presumed that the Tennessee disability determination section is a typical agency in any respect.

Neither should it be presumed that the use of volume providers is a recent innovation. Since the early 1960's, when consultative examinations began playing an increasingly important role in the disability decision, only a limited number of physicians have shown much interest in performing consultative examinations. This reluctance was understandable.

The agency demands were early appointments, quick, comprehensive reports, no payment for broken appointments (in Tennessee) and usually for a substandard fee.

Most practicing physicians are in the business of treating sick folks and are not particularly attracted to social security claimants.

The rehabilitation client wanting to return to work is more attractive than a claimant wanting cash benefits. Some physicians even will treat and see rehabilitation patients at no cost to the agency.

The appointment and reporting demands are also less severe for the rehab client.

The black lung program followed by supplemental security income overtaxed existing cooperative medical sources that forced the DDS into developing high-volume sources for consultative examinations. The increase in claims resulting from these two programs, added to the increasing and specialized types of medical documentation required by the Social Security Administration, further overtaxed available resources.

It should be remembered that this issue deals only with purchased examinations and is separate and apart from paying for evidence of record. Securing well-documented medical reports from attending physicians and private and government hospitals represents other problems. It must also be pointed out that in a slim majority of the decisions made in Tennessee, purchased examinations are not necessary.

Volume providers must be commended for the substantial service rendered social security and the disability determination section. Some irregularities occur. Others are only perceived.

In many SSI claims, so-called volume providers are the only source of substantial medical evidence and, if 75 percent are denied, it is only logical to fault the examining physician.

Rarely, if ever, has there been a complaint from a claimant who is awarded benefits. It follows that volume providers receive their share of the complaints. It may appear that they get more than their share.

A study was conducted in the summer of 1980 and took about a year to complete because of some problems I will go into later, involving the Tennessee DDS No. 1 volume provider, Thurman and Thurman, also known as suburban internal medicine group.

One hundred patients' opinions were elicited 2 to 3 days following the examination, but prior to the making of the decision. Out of 91 responses, 79 said they felt the doctor gave them an adequate examination. It was this same source that was accussed of fraudulent practices.

So, in addition to an apparently high number of complaints involving volume sources, and I might say the number of complaints we received precipitated this study, other possible irregularities include their identity by some as government doctors and those traveling or flying doctors are further suspect as being outsiders.

Their offices are not open every day, they prescribe no medicine, make no house calls, admit no patients to hospitals and, very likely, do not have the expected bedside manner as would an attending physician.

These characteristics in and of themselves represent a deviation from a customary medical practice and, therefore, a possible irregularity.

If the use of volume providers is irregular, the DDS must share the blame. As the pressure for improved documentation and reduced processing time increases, the disability examiner naturally turns to sources best able to deliver both.

The low volume, only occasional source of consultative examinations usually provides an excellent report, but seldom with the desired speed.

An ever-present danger the DDS must guard against is the physician who, trying to respond to the needs of the agency, becomes overzealous, spends too little time with the patient and submits reports not accurately reflecting the patient's condition.

While the DDS and others would question the DDS' authority to police the practice of what is almost becoming a medical specialty, that of disability evaluation, some steps have been taken to preserve the integrity of the consultative examination process.

Admittedly, these have been on a very limited basis. It might be well to mention here that one of the limiting factors has been unavailability of staff within the agency. Our professional relations officer should be working full-time in recruiting physicians and putting out fires that we might have, and eliminating problems with hospitals and other providers.

During last summer, we got in such difficulty with our bill-paying process we had to divert him from what he should have been doing to help alleviate the problem we had with paying the doctors for their services.

These monitoring activities include steps such as unannounced visits to the examination site by a DDS employee, a systematic sampling of examined claimants to obtain their impressions and reactions and the establishment of prescribed requirements for conducting examinations.

Social security has recently issued "Basic Requirements for Consultative Examinations" to which Tennessee has added five additional requirements. These are attachments No. 1 and No. 2.

Some thought must now be given to defining a volume provider. Tennessee uses more than 450 sources for consultative examinations, including physicians in solo practice, group practices, clinics, hospitals, mental health centers, and psychologists.

Of the 450, only 150 received $1,000 or more during the October 1980–July 1981 period. Roughly, it would take 10–20 examinations to earn $1,000, hardly a volume provider.

There were 29 who did at least $10,000 worth of examinations during the 10-month period.

To get a better picture of these top 29, the dollar amount received and their distribution, the following is provided. Bear in mind for a 10-month period, the volume receiving from $10,000 to $15,000 during that period was nine. Four receiving between $15,000 and $20,000. Three between $20,000 and $25,000. One between $25,000 and $30,000. Three between $30,000 and $35,000. One between $35,000 and $40,000. Two between $40,000 and $45,000. Two between $45,000 and $50,000.

Now there were four sources that, during that period of time, received in excess of $50,000. One received $58,437. A Knoxville cardiologist. Another Nashville psychologist received $62,615. A Memphis internist received $96,304. Suburban Internal Medicine Group received $599,300 during that 10-month period.

Mr. PICKLE. Is that the Thurman and Thurman?

Mr. BROWN. Yes, sir.

Mr. PICKLE. $600,000.

Mr. BROWN. During which time they employed 12 physicians. The total amount spent for consultative examinations during the 10-month period is $1,876,175 and is projected to be $2,250,000 for fiscal year 1981.

This approximates the cost for fiscal year 1979 and fiscal year 1980 which were $2,231,951 and $2,344,731 respectively. As you can see, consultative examination costs have remained fairly constant.

It is still not clear which of these sources are volume providers. It is clear that in terms of money paid for services, the 29 providers listed above received $1,402,103 or 75 percent of the total spent for consultative examinations and should at least be considered as possible volume providers.

It is obvious that one provider who employed 12 physicians and had offices in four Tennessee cities got 31.9 percent of the business must certainly be considered a volume provider.

Several sources in the top 29 pretty much limit their practice to disability evaluations and have little; if any, private practice. Others have quite a large private practice and for one reason or another see a number of disability applicants.

It should be clearly understood that except for one vendor, the largest in terms of money received, all of them have established permanent offices and are a part of the medical community, being board-certified or board-eligible with hospital privileges. All are licensed in Tennessee.

The largest provider has an established practice in Nashville, Vanderbilt graduate, board-certified in internal medicine, has hospital privileges and, at one time, examined claimants 2 to 3 days a week, I am uncertain as to the number of days, in Nashville, Chattanooga, Knoxville, and Kingsport, with the help of 11 other physicians and support personnel.

It was this group that was accused of fraud, later temporarily suspended by both social security and the Tennessee DDS, but who are now back in business in Nashville and Knoxville. They disposed of the Chattanooga operation and the unfavorable publicity prohibited their return to Kingsport.

Although their suspension lasted only 7 weeks, the publicity and loss of their services played havoc with the DDS. Cases which were already backlogged due to staff shortages, personalized denial letters, and the flood of continuing disability cases, ground to a halt.

This served to highlight the risk involved in over-utilizing one group.

The alternatives were and are extremely limited. The agency is bound by a fee schedule that remains essentially unchanged since 1978. The substandard fee, coupled with the demand for early appointments, quick and comprehensive reports, make doing business with the DDS not too attractive for physicians with large private practices.

It may be, however, more attractive to physicians and groups who can specialize in disability examinations or who can devote a portion of their practice to such activities.

To do so requires some streamlining of examining and reporting procedures that give rise to alleged irregularities.

With the loss of the Kingsport office for examinations in upper east Tennessee, the agency has redoubled its recruitment efforts without much success. Many applicants will now have to travel 115 miles to Knoxville and wait several weeks for an appointment since the Kingsport area cannot begin to absorb the 200 internal medicine examinations needed monthly in that area.

This will obviously increase processing time, increase the number of delayed claims and create further increase in workload.

Under more normal circumstances, the disruption resulting from the temporary loss of Tennessee's major source for consultative examinations would have been less catastrophic. The timing of this crisis could not have been worse.

Since prior to 1978 and until July 1981, the Tennessee DDS has had a staff ceiling of 213 positions. From March 14, 1980 until 50 new positions were approved July 15, 1981, Tennessee State government was under a hiring freeze that no amount of persuasion could thaw.

The agency was in no condition, and is not now, to assume accelerated continuing disability cases in March 1981, but there was no apparent alternative.

Three weeks ago, 66 boxes of accelerated continuing disability cases were received in a single week. The agency was in no condition, and is not now, to assume personalized denial letters in July 1981, but those pleas, likewise, fell on deaf ears.

On February 26, 1981, SSA advised the Tennessee DDS to increase its staff by 50 positions. On March 10, 1981, it was told to add 71 more positions. The first 50 positions were approved July 15, 1981, and are now in the process of being filled. It is unlikely the remainder will be approved prior to July 1982.

In the meantime, the agency backlog has increased from 7272 cases on March 1, 1981, to approximately 15,000 cases today with essentially no additional help. Twenty examiner trainees were employed September 1, 1981, but will not be productive for several months yet.

The Members and social security need to realize that budgeting money and authorizing staff for State operations doesn't always bring the desired results. This is a State-managed program, and the State is often not in a position to respond as quickly as does the need.

For about 1½ years, almost 2 years, the agency has been developing and acquiring a computer-driven word-processing system to assist with the very heavy correspondence going to doctors and hospitals.

As delivery time approached, the system was diverted to process personalized denial notices and is now bogged down with trying to keep up with 15,000 cases. A duplicate system is now being considered, roughly 90 days after the first one was put in place, because of this unprecedented workload.

It is unlikely that the agency will be back to normal before the summer of 1982 during which time processing time and perhaps quality will fall below acceptable levels.

A copy of Tennessee's basic examination fee schedule is attached as exhibit number 13.

[The prepared statement follows:]

STATEMENT OF HERBERT L. BROWN, DIRECTOR, DISABILITY DETERMINATION SECTION, NASHVILLE, TENN.

POSSIBLE IRREGULARITIES IN MEDICAL EXAMINATIONS PURCHASED FROM "VOLUME PROVIDERS"

Perhaps it's not altogether unfortunate that a federal judge "shoots from the hip" and accuses a volume provider of medical reports as fraudulent. By so doing, whether substantiated by the facts or not, the judge has brought to near national attention standard operating procedures used by many, if not most, states; that being, the use of a limited number of physicians to perform the bulk of the consultative examinations needed by a state disability determination agency.

This testimony, however, will deal with what occurs in Tennessee. It should not be presumed that the Tennessee Disability Determination Section is a typical agency in any respect.

Neither should it be presumed that the use of "volume providers" is a recent innovation. Since the early 1960's, when consultative examinations began playing an increasingly important role in the disability decision, only a limited number of physicians have shown much interest in performing consultative examinations. This reluctance was understandable. The agency demands were early appointments, quick, comprehensive reports, no payment for broken appointments (in Tennessee) and usually for a sub-standard fee. Most practicing physicians are in the business of treating sick folks and are not particularly attracted to social security claimants. The rehabilitation client wanting to return to work is more attractive than a claimant wanting cash benefits. The appointment and reporting demands are also less severe for the rehab client.

The Black Lung Program followed by Supplemental Security Income over-taxed existing cooperative medical sources that forced the DDS into developing high volume sources for consultative examinations. The increase in claims resulting from these two programs, added to the increasing and specialized types of medical documentation required by the Social Security Administration further overtaxed available resources.

It should be remembered that this issue deals only with purchased examinations and is separate and apart from paying for evidence of record. Securing well documented medical reports from attending physicians and private and government hospitals represents other problems. It must also be pointed out that in a slim majority of the decisions made in Tennessee, purchased examinations are not necessary.

Volume providers must be commended for the substantial service rendered Social Security and the Disability Determination Section. Some irregularities occur. Others are only perceived. In many SSI claims, so called volume providers are the only source of substantial medical evidence and, if 75 percent are denied, it's only logical to fault the examining physician. Rarely, if ever, has there been a complaint from a claimant who is awarded benefits. It follows that volume providers receive their share of the complaints. It may appear that they get more than their share.

A study was conducted in the Summer of 1980 involving the Tennessee DDS's number one volume source. One hundred patients' opinions were elicited 2-3 days following the examination, but prior to the making of the decision. Out of 91 responses, 79 said they felt the doctor gave them an adequate examination. It was this same source that was accused of fraudulent practices.

So in addition to an apparently high number of complaints involving volume sources, other possible irregularities include their identity by some as government doctors and those traveling or flying doctors are further suspect by being outsiders. Their offices are not open every day, they prescribe no medicine, make no house calls, admit no patients to hospitals and, very likely, do not have the expected bedside manner as would an attending physician. These characteristics in and of themselves represent a deviation from a customary medical practice and, therefore, a possible irregularity.

If the use of volume providers is irregular, the DDS must share the blame. As the pressure for improved documentation and reduced processing time increases, the disability examiner naturally turns to sources best able to deliver both. The low volume, only occasional source of consultative examinations usually provides an excellent report, but seldom with the desired speed.

An ever-present danger the DDS must guard against is the physician who, trying to respond to the needs of the agency, becomes overzealous, spends too little time with the patient and submits reports not accurately reflecting the patient's condition.

While the DDS and others would question the DDS's authority to police the practice of what is almost becoming a medical speciality, disability evaluation, some steps have been taken to preserve the integrity of the consultative examination process. Admittedly, these have been on a very limited basis. They include such steps as unannounced visits to the examination site by a DDS employee, a systematic sampling of examined claimants to obtain their impressions and reactions and the establishment of prescribed requirements for conducting examinations. Social Security has recently issued "Basic Requirements for Consultative Examinations" to which Tennessee has added five additional requirements. These are attachments Nos. 1 and 2.

Some thought must now be given to defining a volume provider. Tennessee uses more than 450 sources for consultative examinations including physicians in solo practice, group practices, clinics, hospitals, mental health centers and psychologists.

Of the 450, only 150 received $1,000 or more during the October 1980-July 1981 period. Roughly it would take 10-20 examinations to earn $1,000, hardly a volume provider.

There were 29 who did at least $10,000 worth of examinations during the above 10-month period.

To get a better picture of these top 29, the dollar amount received and their distribution, the following is provided:

Payment range:	Number of vendors
$10,000 to $15,000	9
$15,001 to $20,000	4
$20,001 to $25,000	3
$25,001 to $30,000	1
$30,001 to $35,000	3
$35,001 to $40,000	1
$40,001 to $45,000	2
$45,001 to $50,000	2
Above $50,000:	
$58,437	1
$62,615	1
$96,304	1
$599,300	1

The total amount spent for consultative examinations during the 10-month period is $1,876,175 and is projected to be $2,251,300 for fiscal year 1981. This approximates the cost for fiscal year 1979 and fiscal year 1980 which were $2,231,951 and $2,344,731 respectively. As you can see, consultative examination costs are fairly stable.

It still is not clear which of these sources are volume providers. It is clear that in terms of money paid for services, the 29 providers listed above received $1,402,103 or 75 percent of the total spent for consultative examinations and should at least be considered as possible volume providers.

It is obvious that one provider who employed 12 physicians and had offices in 4 Tennessee cities got 31.9 percent of the business must certainly be considered a volume provider. Several sources in the top 29 pretty much limit their practice to disability evaluations and have little, if any, private practice. Others have quite a large private practice and for one reason or another see a number of disability applicants.

It should be clearly understood that except for one vendor, the largest in terms of money received, all of them have established, permanent offices and are a part of the medical community, being board certified or board eligible with hospital privileges. All are licensed in Tennessee.

The largest provider has an established practice in Nashville, board certified in internal medicine, has hospital privileges and, at one time, examined claimants 2 to 3 days a week in Nashville, Chattanooga, Knoxville and Kingsport with the help of 11 other physicians and support personnel.

It was this group that was accused of fraud, later temporarily suspended by both Social Security and the Tennessee DDS, but who are now back in business in Nashville and Knoxville. They disposed of the Chattanooga operation and the unfavorable publicity prohibited their return to Kingsport.

Although their suspension lasted only 7 weeks, the publicity and loss of their services played havoc with the DDS. Cases which were already backlogged due to staff shortages, personalized denial letters and the flood of continuing disability cases, ground to a halt. This served to highlight the risk involved in over-utilizing one group.

The alternatives were and are extremely limited. The agency is bound by a fee schedule that remains essentially unchanged since 1978. The sub-standard fee coupled with the demand for early appointments, quick and comprehensive reports, make doing business with the DDS not too attractive for physicians with large private practices. It may be, however, more attractive to physicians and groups who can specialize in disability examinations or who can devote a portion of their practice to such activities. To do so requires some streamlining of examining and reporting procedures that give rise to alleged irregularities.

With the loss of the Kingsport office for examinations in upper East Tennessee, the agency has re-doubled its recruitment efforts without much success. Many applicants will now have to travel 115 miles to Knoxville and wait several weeks for an appointment since the Kingsport area cannot begin to absorb the 200 examinations needed monthly in that area. This will obviously increase processing time, increase the number of delayed claims and create further increase in workload.

Under more normal circumstances, the disruption resulting from the temporary loss of Tennessee's major source for consultative examinations would have been less catastrophic. The timing of this crisis could not have been worse.

Since prior to 1978 and until July 1981, the Tennessee DDS has had a staff ceiling of 213 positions. From March 14, 1980 until 50 new positions were approved July 15, 1981, Tennessee State Government was under a hiring freeze that no amount of persuasion could thaw.

The agency was in no condition to assume accelerated continuing disability cases in March 1981, but there was no apparent alternative.

The agency was in no condition to assume personalized denial letters in July 1981, but those pleas likewise fell on deaf ears.

On February 26, 1981, SSA advised the Tennessee DDS to increase its staff by 50 positions. On March 10, 1981, it was told to add 71 more positions. The first 50 positions were approved July 15, 1981 and are now in the process of being filled. It is unlikely the remainder will be approved prior to July 1982.

In the meantime, the agency backlog has increased from 7272 cases on March 1, 1981 to approximately 15,000 cases today with practically no additional help. Twenty examiner trainees were employed September 1, 1981, but will not be productive for several months yet.

The Members and Social Security need to realize that budgeting money and authorizing staff for state operations doesn't always bring the desired results. This is a state managed program and the state is often not in a position to respond as quickly as does the need.

For about a year and a half, the agency has been developing and acquiring a computer driven word processing system to assist with the very heavy correspondence going to doctors and hospitals. As delivery time approached, the system was diverted to process personalized denial notices and is now bogged down with trying to keep up with 15,000 cases. A duplicate system is now being considered to process the unprecedented workload.

It is unlikely that the agency will be back to normal before the summer of 1982 during which time processing time and perhaps quality will fall below acceptable levels.

A copy of Tennessee's basic examination fee schedule is attached as exhibit No. 3.

[Exhibit No. 1]

SOCIAL SECURITY'S BASIC REQUIREMENTS FOR CONSULTATIVE EXAMINATION

1. For reporting of a general internal medical or family practice examination, the following is expected:

A. The detail and format for reporting the results of the history, physical examination, laboratory findings, and discussion of conclusions should follow the standard reporting principles for a complete and competent medical examination.

B. The major or "chief complaints" should be identified under "chief complaints".

C. Each of these major or chief complaints should be discussed in detail under the section which may be called "History of Present Illness." The discussion of these complaints must be the pertinent past history of the disease state in addition to the detailed description of the individual's statement of his current complaint. It is important to present, in as great detail as can be obtained from the individual, significant occurrences, including changes in the status of that complaint over time, hospitalizations with dates and names of hospitals, findings and treatment during the hospitalization as understood by the individual, and ongoing treatment. It is particularly important to provide a detailed description of the individual's current complaints explaining those factors which increase the problem or impairment and those which may provide relief, and how the individual describes how the impairment limits his or her ability to function. Current medication should be listed by name of drug and dose.

D. The "Review of Systems" should state and describe other minor complaints and should provide pertinent negative findings according to the standard format for a general internal medical examination.

E. Pertinent findings under "Social" (e.g., use of tobacco products, alcohol, nonprescribed drugs) and "Family" history should be presented.

F. The physical examination must provide a description of the individual's general appearance and pertinent actions during the examination (e.g., for an individual with a complaint of back or other musculoskeletal disease, how he or she got up from a chair, got on and off the examination table).

Those aspects of the examination dealing with the individual's major and minor complaints should be presented in particular detail, describing pertinent negative findings as well as the positive findings.

The remainder of a standard internal medical examination should be described, excluding the pelvic, rectal, and breast examination, except where those findings are particularly pertinent to the complaint. If the individual's complaints indicate the need to perform a pelvic or rectal examination, but this has not been done, this fact should be reported for consideration of further specific examination.

In addition to reporting the individual's height (without shoes), weight, and blood pressure, the pulse rate must be reported.

Report specific range of motion of joint in degrees. This should be done for joints in which there is found a significant limitation of motion. If a joint is found to have no abnormality of range of motion on gross examination, that fact should be stated rather than reporting the degrees of motion.

G. The actual reported values for laboratory tests must be given. This may be in the attached laboratory report instead of being in the body of the medical report. Electrocardiographic tracings and spirographic tracings must be provided when these tests have been performed. (Legible copies are acceptable). When ventilatory function tests have been performed, the reported findings must meet the requirements of Section 3.00 of the Listing of Impairments. The interpretation of laboratory tests, such as electrocardiographic tracings, and be correlated with, the history and physical examination findings. The selection of joints to be x-rayed as representative of most involved by disease must be based on the results of the physicians examination.

2. The physician signing the report must review the reported history and physical examination findings which must represent the information which he or she has obtained in his or her examination of the individual. The conclusions which are provided by this physician must correlate the findings from the history, physical examination, and laboratory tests. All abnormalities should be explained, or commented upon if a definitive explanation cannot be provided. This physician must also sign the report.

3. The physician or medical group must be immediately responsive to complaints and requests for clarification. If not responsive, it may be necessary to seek other sources.

[Exhibit No. 2]

BASIC REQUIREMENTS FOR CONSULTATIVE EXAMINATIONS

The following requirements have been added by the Tennessee Disability Determination Section to Social Security's "Basic Requirements for Consultative Examinations."

1. No more than three examinations should be scheduled or performed per hour with a minimum of 15 minutes spent in examining each patient. The physician should explain the purpose of the examination, that the results will be considered with other medical and vocational evidence and not attempt should be made by the physician to predict whether the patient will be found disabled.

2. The patient should be treated as a private patient with genuine concern shown for the patient's complaints and feelings. The patients' perception of the examination is very important to obviate the impression they are being run through "an examination mill" or treated like so many animals. They must be treated with dignity.

3. The physician's office should look like a physician's office and their staff should both look and act as appropriate for a physician's office. The physician is responsible for having assistants properly trained to perform their various functions.

4. Equipment used in the course of the examination must be accurately calibrated and clean and make a positive influence on the patient. Garments should be removed prior to x-rays in keeping with customary medical practice. Female patients should be provided a gown.

5. The report must accurately reflect what occurred during the examination and be tailored to the examination without the inclusion of unnecessary verbage serving no real purpose. Negative findings should be worded so as to eliminate the appearance of all reports looking alike.

[Exhibit No. 3]

Special Examinations (Customary fees subject to the following upper limits) these fees are for the history and physical examination only and do not include other services such as lab work, x-rays, etc. Authorizations and payments for additional services will be made in accordance with the upper limits described in the appropriate manual sections.

Allergist	$57.40
Cardiologist	57.40

Dermatologist	$25.00
Emergency room based physician	38.00
Family practitioner—Reported in narrative form or on comprehensive DDS form	30.00
Internist	57.40
Neurologist and/or neurosurgical	57.40
Gynecologist	25.00
Oncologist	57.40
Opthalmologist (including refraction)	32.80
Orthopedist	38.30
Otolaryngologist (including audiometric)	38.30
Pediatrician	38.30
Physiatrist	57.40
Psychiatrist	57.40
Radiologist	38.30
Surgeon	38.30
Urologist	38.30

NOTE.—Hospital Admission Examination—when requested by admitting physician—not to exceed $25.

Tennessee disability determination section—Radiology

	Maximum fee
Chest:	
Single view (AP)	$21.00
Two views (AP and L)	28.00
Spine and pelvis:	
Cervical:	
1 view	24.50
2 views	35.00
3 views	39.45
4 views	43.90
Thoracic (dorsal):	
1 view	24.50
2 views or more	31.10
Lumbo-Sacral:	
1 view	24.50
2 views	35.50
3 views	38.00
4 views	40.50
5 views or more	42.90
Pelvis:	
1 view	24.50
2 views	35.50
Upper extremities:	
Clavicle	18.80
Scapula	24.00
Shoulder:	
1 view	22.00
Complete	27.50
Humerus and 1 joint (specify)	24.50
Elbow, 2 views	22.00
Complete (3 views or more)	31.00
Forearm and 1 joint (specify)	21.30
Wrist, 2 views	21.30
Complete, minimum 3 views	26.70
Hand	20.80
Fingers	17.80
Lower extremities:	
Hip, 1 view	27.00
Complete	33.00
Femur and 1 joint (specify)	25.20
Knee, 2 views	23.50
Complete, minimum 3 views	32.50
Tibia and fibula (leg) including 1 joint (specify)	21.00
Ankle, 2 views	23.00
Complete, minimum 3 views	26.20
Foot, 2 views	23.00
Complete, minimum 3 views	34.00

OS calcis (heel) 2 views	20.00
Toes	20.00
Abdomen, GI, GU:	
Abdomen, single view AP	26.50
Upper GI tract, with or without delayed films	64.70
Kidney, ureter and bladder (KUB), single view	25.20

Mr. **Brown**. I would like to request that another report on the recruiting, which I do not have sufficient copies of, also be included in my testimony.

That concludes it, Mr. Chairman.

Mr. **Pickle**. Without objection, it will be included in the full record.

[The information referred to follows:]

[Exhibit No. 4]

Disability Determination Section,
Nashville, Tenn., September 10, 1981.

Re Recruiting Report.

To: Herbert L. Brown, Administrator.
From: Roger Flannery, Professional Relations Officer.

BRIEF HISTORY

With the advent of SSI in 1974, additional sources for Consultative Examinations were needed. Although the recruiting effort was increased, the greater success was found in large metropolitan areas. As in many states, Tennessee has a physician distribution problem, with several rural counties underserved to various degrees. SSA discussed the possibility of states' considering the use of volume sources where appropriate.

The Tennessee agency used a volume source, Internal Medicine Associates, in two cities in the mountainous eastern part of the state, along with one city in the mid-western area of the state. This source did not prove satisfactory, and in mid-1977, another source developed into a volume examiner, eventually incorporated under the name Thurman and Thurman, M.D.'s, P.C. Later, the name was changed to Suburban Internal Medicine Group, P.C., reflecting the participation of several physicians other than the Thurman brothers who founded the firm.

REGULAR RECRUITING PROGRAM

The ongoing program of recruiting in the Tennessee DDS consists of the following: (1) approximately every two weeks, the State Licensing Board sends a list of newly licensed physicians in Tennessee. contact is made with each physician with a letter from the Chief Medical Consultant and the Professional Relations Officer, along with a questionnaire to be returned if the physician is interested in learning more about the program. This has proven to be the most reliable and effective means of gathering leads on CE panel members; (2) an exhibit is manned at medical conventions, such as at the annual Tennessee Medical Association meetings, the Tennessee Psychological Association meetings, and the like; (3) referrals are solicited from Social Security District and Branch Office managers and staff, Division of Vocational Rehabilitation staff, and from Congressional office staff members at various locations in the state; (4) as the telephone directories are revised annually, the Yellow Pages are reviewed for new physicians in needed specialties, who might not have been identified by other means; (5) staff members at medical schools in the state are contacted from time to time (to date, this has not proven to be significantly helpful, as most physicians are already identified by one of the other avenues discussed above); (6) DDS staff, both lay disability examiners and in-agency physicians, occasionally suggest contacts, either with physicians who are personal friends or acquaintances, or who have submitted good quality reports of medical evidence of record to the agency.

CHALLENGES TO RECRUITING

Although there are several advantages in serving on the consultative examiner panel, including the opportunity to observe a variety of medical conditions possibly not encountered in regular private practice, no significant collection problems or billing procedures, no need to build up the regular patient load, and the like, there also are negative factors. The most significant of these relate to the effort required balanced against the present level of reimbursement in Tennessee.

The Social Security disability program requires very objective and detailed medical examinations and reports, in order to document impairments in terms of program criteria. Consultant examiners usually spend more time with the examination and preparation of the report than they would with a private patient, possibly even on a consultation for another physician. At the same time, the maximum allowable fee schedule in Tennessee, one of the more fiscally conservative states, typically does not reimburse the physician at or even near the level of his usual charges for such service.

The fee schedule is promulgated by the Department of Finance and Administration with the cooperation of the current State Medicaid vendor. With but few adjustments, this fee schedule is then given to the DDS parent agency, the Division of Vocational Rehabilitation. Although there is a DVR Medical Advisory Board which can discuss fee levels, among other items, this Board normally meets only once every other year, and has not met in almost three years due to lack of available funding for the last scheduled meeting. The fee schedule does not have a provision for an annual or other regular interval fee adjustment, and the fee schedule currently in use was issued in July, 1978, with only a few relatively minor adjustments in certain fees since that time.

Most of the CE panel members in 1978 accepted an upward adjustment in their basic fee (for taking the medical history, performing the examination, and processing a typed narrative report), and there were relatively few complaints about the fee schedule in the last half of 1978 and during much of 1979. Since then, a list maintained by the Professional Relations Officer of physicians and psychologists who have expressed repeated concern over the fee schedule is growing. There are currently twelve such names, and in addition, 19 physicians, including 9 internists, 5 psychiatrists, 2 orthopedists, 2 neurologists, and 1 cardiologist, have asked within the past 18 months to be removed from the panel, the reasons for which included concern over the fee schedule. Usually, such a decision is prompted by more than one factor, but the fee schedule was mentioned in several of these cases, and in five cases was given as the primary or only reason for resigning.

The specialties indicating the greatest concern have been: orthopedists, psychiatrists, family practitioners, internists, and psychologists.

A frequent complaint is that disability applicants are more prone not to keep appointments than private patients, and the Tennessee agency does not have a provision for paying a fee in such an event.

Another significant event related to the fee schedule occurred in the fall of 1980, when silver prices rose dramatically, with X-ray film prices also rising. There was no provision for flexibility to adjust the DDS's fee maximums for radiology, and several physicians who formerly accepted authorization for X-rays, even though the local hospital actually provided the X-ray and interpretation, notified us to stop authorizing payment to them. The reason was that the hospital was now billing the physician a greater amount than we were able to reimburse. In some such cases, we were not able to persuade the hospital and/or radiologist to accept our fee maximums, and the consulting physician was limited to examinations not involving radiology. Even in cases in which the hospital and radiologist agreed to our fees, additional paperwork resulted to an already overburdened DDS clerical staff, due to the need for the additional one or two authorization forms.

In the opinion of the Professional Relations Officer, the DDS needs to be included in the deliberations prior to the periodic establishment of the statewide maximum fee schedule. While the current process generally has worked fairly well, there are a certain number of medical studies in which the documentation approach required by the disability program differs from the rehabilitation approach. It is recommended that consideration be given to a small fee adjustment annually, rather than waiting three or more years between adjustments. It appears that most consulting physicians would prefer even a very small annual adjustment rather than a "long dry spell."

The above discussion applies to the current federal-state arrangement. Since fee schedules in various states are reportedly a problem to their operations, it could be pointed out that federalizing the disability determination process might eliminate the fee conflict.

SUSPENSION OF VOLUME SOURCE AND CURRENT RECRUITING

In July, 1981, a Federal District Court Judge found that certain reports and practices of Suburban Internal Medicine Group were "fraudulent," with respect to certain applicants in Virginia. Nine days later, Social Security Administration instructed those states who were obtaining CE's from this firm to suspend their use until an investigation could be made. After such SSA investigation, the suspension was lifted. An FBI investigation requested by the federal judge has not been completed at this time. Since the CE's in question were performed in Kingsport, Tennessee, just across the Virginia state line, widespread media coverage was given to the judge's decision and succeeding events. Due to hostility among the general public in that area, SIMG has decided not to reopen an examining office in that general area.

Kingsport, with Bristol and Johnson City, comprise the Tri-Cities area of extreme North-east Tennessee. It is estimated that 200 CE's are needed from specialists in internal medicine each month in the Tri-Cities area, for Tennessee applicants alone. Historically, this section of the state has been underserved, particularly by specialists. When a given specialist moves into the area, he or she typically becomes quite busy with private patients, and is not willing to schedule consultative exams for this agency, particularly given the negative factors in relation to the allowable fee maximums, as discussed above. The Suburban Internal Medicine Group was able to supply our needs, by training an efficient staff to perform various examination and report processing methods, and by purchasing supplies in quantity. The usual distractions in a physician's private office, such as telephone interruptions, were not a factor. Average number of examinations performed per hour was monitored occasionally, and was found at most to be 4.2 or 4.3. This number included certain applicants who were examined for limited studies only, such as an X-ray or pulmonary function testing only. Average contact time by the physician himself was observed by the Professional Relations Officer to be 15 minutes; and such time was estimated by several claimants, surveyed a day or two after the examination but prior to receiving any notice of eligibility or non-eligibility, at 25.6 minutes in the Kingsport office.

Upon the suspension of SIMG, an immediate effort was begun to notify all specialists in internal medicine in the eastern third of the state of our extreme need for additional consultant support. A memorandum with various informational material was mailed to 231 internists not currently serving on the CE panel. These physicians were located in the 35 counties touching or east of the 85 degree line of longitude.

It should be noted that actually only 20 counties were involved, since 15 of these counties did not have any specialists, in internal medicine. Of the 231 physicians, only 14 have responded to date, indicating an interest in discussing the program further. In addition, two physicians responded during this time as a result of the regular recruiting mailouts, and three names of internists were recently furnished by SSA District Office personnel. Of these 19, nine were definitely interested in performing at least some CE's, and nine of the remaining ten appear to be probable panel members as soon as further discussions take place. The "definite" prospects will be added to our CE Vendor Manual as soon as the necessary accounting vendor numbers can be obtained from the State Department of Finance and Administration.

With respect to the Tri-Cities area alone, however, there are only two "definites," an additional two internists who are restricting their referrals to problems primarily in their sub-specialty, and two additional "probables." Obviously, the prospects of obtaining CE support for the needed volume of 200 exams per month in this area alone is far from being realized. In the meantime, the DDS staff continues to accept appointments from the few current members of the CE panel late into this year, or ask claimants to travel approximately 115 miles to Knoxville if possible, in order to obtain a more favorable CE appointment.

One potential source for additional CE support lies in the numbers of Family Practitioners in this area, many of whom are coming out of the new medical school in Johnson City. To date, they have been unwilling to perform the detailed examination and report required for the maximum allowable $30 fee, stating that it costs almost that much to dictate a report, have it typed, possibly corrected and re-typed, without considering a history/physical.

Forthcoming efforts in recruiting will include further contacts with the medical school faculty and staff, contacts with the VA Medical Facility in Johnson City, local medical society meeting contacts, and advertisement/press releases for medical journals and newspapers. However, it may be that only limited to moderate success will be realized, and probably nowhere near the volume requirements for CE's will be reached until the following occur:

(1) A maximum fee is established for "comprehensive physical examination with history and report" whether performed by specialists in internal medicine or family/general practice, and at a level in the approximate $60-$75 range.

(2) Maximum fees for certain ancillary studies are increased to a reasonable level, so as to make it practical for a physician to accept DDs authorization, reimbursing other sources for studies he is not able to furnish in his office, thus giving the DDS

some relief on paperwork. Three such categories most critical are radiology, EKG's, and pulmonary function tests.

(3) Increase the base fee for examinations performed in the following specialties, in addition to (1) above: orthopedic, psychiatric, internal medicine, and psychological evaluations. Of these, probably only a modest increase is needed except for orthopedic exams, where a more significant increase appears indicated. Possibly, consideration should be given to a modest orthopedic fee increase with an additional amount if lower spine pathology requires evaluation.

(4) As discussed above, consideration is requested to granting even a very small annual fee adjustment, and to strategies for responding to unusual fee-related challenges, such as the recent dramatic increase in silver prices and the related effect on X-ray film prices.

SIX TO TWELVE MONTH OUTLOOK

It is anticipated that some additional CE sources will be recruited in the Tri-Cities area and in other locations where needed. Implementation of at least some of the recommendations with respect to the State fee structure, discussed above, might enhance such recruiting to some degree, and possibly to a significant degree. However, based on past program experience and increasing case receipts, it is quite possible that the services of another source for a relatively high volume of consultative exams in certain medical specialties will be needed in certain areas of the state, particularly in East Tennessee.

Mr. **Pickle**. Mr. Bailey.

Mr. **Bailey**. Thank you, Mr. Chairman.

Mr. Lowe, I have a couple of very quick questions I would like to ask you. Do you remember, you were here when I read the copy of the directive from the Social Security Office of Operational Policy and Procedures wherein certain statistical information was requested.

Did that ever reach you? Do you have any knowledge off the top of your head whether any requests were made of you for that type of information from the regional office?

Mr. **Lowe**. Yes, we do have it.

Mr. **Bailey**. Are you in the process of providing that information now?

Mr. **Lowe**. I understand we already have done that, Congressman.

Mr. **Bailey**. You have already complied?

Mr. **Lowe**. Yes.

Mr. **Bailey**. When did you comply? Did you comply by the August 3 date, to your knowledge?

Mr. **Lowe**. I believe we did.

Mr. **Bailey**. So you did communicate that information to Social Security?

Mr. **Lowe**. Correct.

Mr. **Bailey**. You earlier alluded that you are presently looking at these practices now, is that correct?

Mr. **Lowe**. That's correct.

Mr. **Bailey**. I understand Mr. Moushey has been making inquiries. Has he informed your office of some of his findings on investigating certain group practices and certain individuals that might be connected with some of this group practice in various volume provider work in various States?

Mr. **Lowe**. Mr. Moushey and I have been in communication, yes.

Mr. **Bailey**. I would like to make a request of you publicly. When you have finished your investigation, would you please commit yourself to providing information to the subcommittee, to Chairman Rangel's subcommittee, on what you find, and keep them updated?

Would you do that, please?

Mr. LOWE. I would be very pleased to do that.

Mr. BAILEY. Mr. Brown, I will be quick again. One thing has been a little confused. We are talking about the alleged irregularities. In the information that was provided by Mr. Moushey to our subcommittee, it seems that there is a fellow by the name of Dr. Richard Lipman.

Was he operating, or was his name involved in the Tennessee situation there?

Mr. BROWN. Not recently.

Mr. BAILEY. Was there any connection at all between Thurman & Thurman, and Lipman?

Mr. BROWN. Not to my knowledge. We think not.

Mr. BAILEY. Mr. Lowe, it appears in our subcommittee report, that "1977, Dr. Lipman was indicted by a Federal grand jury for receiving kickbacks and bribes," those words are in quotes, "from laboratory providers of medical services and pleaded guilty to two counts."

The Commissioner, in his letter to Mr. Pickle, wrote following his indictment in 1977, that the Social Security Administration took steps to discourage the States from using his services. July 1977, Dr. Lipman stopped performing regularly scheduled examinations himself and assumed an administrative role. Our information is that Dr. Lipman now is providing services in Pittsburgh, Pa., for consultative examination purposes.

Do you have knowledge of that?

Mr. LOWE. I have no knowledge of that, but I should surely like to know about that if it is so. I will look into it.

Mr. BAILEY. That is something, perhaps, we should look at. Is there any way you can look at the information that came to you to see whether or not Social Security ever notified you of what went on in Tennessee, aside from the communication that I read to you?

Do you know, off the top of your head?

Mr. LOWE. I do not know, but I will find out.

Mr. BAILEY. Mr. Brown, this is really my last question here. What actions did Social Security take after the situation arose? Did they notify you of the problem, or what did they do, and how?

Mr. BROWN. Yes, and we immediately suspended the use of them until such time as they could be investigated and determined whether there was any evidence of fraud.

They later interviewed our staff and physicians along with the States of Georgia and Virginia. I am not sure where they went. Based on that investigation, we lifted the suspension.

Mr. BAILEY. I will end just with saying I think the role and function of the consultative examination procedure is obviously very important and necessary in light of the apparent reluctance of treating physicians, particularly, to supply medical information.

That is very sad. It is also obvious that something out there smells. There needs to be some kind of evaluation or supervision that obviously is not there. Especially if somebody is out there flying around the country making a fortune on this. Apparently, if this fellow is active—and he is—he stands to make a great deal of money on it, and he's going to risk, I guess, accusations if he is acting improperly. There's got to be some lucrative money in it somehow.

I think it is obvious that you folks out there better get on your horses and start investigating this thing right away and thoroughly. Social Security Administration is, I guess, more our affair.

Mr. Chairman, I don't have any more questions. I thank you for being so indulgent with me on time.

Mr. RANGEL. Mr. Brown, how long have you been involved in reviewing disability determinations?

Mr. BROWN. Since 1955.

Mr. RANGEL. Well, I guess we won't be able to get any closer to an expert than you.

Mr. BROWN. You might be able to.

Mr. RANGEL. I get the impression that it is your professional opinion that volume demands require volume providers. The doctors that get involved in this receive fees less than doctors that provide medical services, so therefore, we are talking about a different type of doctor, generally, that would accept this type of work.

Mr. BROWN. A different type in what respect? In terms of just the practice?

Mr. RANGEL. Well, I don't want to open the committee up to any type of liable suits, but I gather from your testimony that there is a difference between a doctor that treats sick folks and a doctor that gets involved in receiving Federal payments for examining people for claims.

Mr. BROWN. Let me correct that. For the most part, doctors that see sick folks do consultative examinations for us. There are a very few that would limit their practice to primarily doing disability evaluations.

Mr. RANGEL. OK. I am talking about the doctors that don't open their offices every day, prescribe no medicine, make no house call, admit no patients.

Mr. BROWN. These are doctors that are out stationed. This group is based in Nashville, the two brothers, Doctors Thurman and Thurman, do have a private practice and they do those things. When they visit Knoxville, Kingsport, and Chattanooga, this is an out station, and these things do not take place there.

Mr. RANGEL. How could the Federal Government make your job easier?

Mr. BROWN. The State of Tennessee—saying this at some risk—could make my job a little bit easier. We are woefully understaffed. We need two professional relations officers to be recruiting and monitoring what is going on. We need additional medical staff. We are operating with about two-thirds of the staff we need.

Mr. RANGEL. When you fill our all of those social security forms in answer to the questions, will the State of Tennessee be able to officially indicate that they can't do any better with the lack of professional staff that they have?

Mr. BROWN. I am sorry, would you repeat the question?

Mr. RANGEL. What we are saying, we are giving a hard time to the Social Security Administration because we don't believe that they have a handle on the problem. You are right there where the problem is. You are saying you don't have a handle on it because you don't have adequate staff. We can go on and on, but we can't really correct the problem until someone is as candid as you are.

So my question is, when the Social Security Administration gets the answers to their questions which they sent to you, or maybe you had already responded, maybe you have, too, but will we in the Congress get some answers like you have just given us, that we would like to do a better job but we are woefully understaffed, and until we get more personnel you should not expect that we will be performing better?

That is what I am saying. Will that be in the official report to Social Security?

Mr. **Brown**. I think it is of record now. I think they see our accuracy diminishing, our processing time increasing, caseload doubling. I don't want to cop out and say our problem is just lack of staff. There are some other problems there, too. This is the primary problem. We have had some work dumped on us that we couldn't handle. We are called the first week in March and told by the middle of March we would begin receiving 800 cases a month, less than 10 days' notice.

Mr. **Pickle**. Who told you that you would be handling these many cases?

Mr. **Brown**. Social Security. This was accelerated continued disability caseload.

Mr. **Pickle**. That was for this past year?

Mr. **Brown**. Yes, sir.

Mr. **Pickle**. I want to make it plain, they were accelerating the review of disability cases. This is not the periodic review, which is effective in January of next year, this is just an accelerated order the Administration made?

Mr. **Brown**. Yes, sir. Those cases have been stacked up in boxes in the corner of our office for several weeks. We could not possibly get to them. This is the kind of situation this State agency is in. It doesn't look very favorable for the near future.

Mr. **Rangel**. Do you see this as a State problem, or Federal problem?

Mr. **Brown**. Monitoring the physicians?

Mr. **Rangel**. Getting rid of your caseload?

Mr. **Brown**. Obviously it is a joint problem. It is a joint relationship. Although we are under regulation and not under an agreement, we both have the responsibility for it. Regulations have not assisted Social Security at all in their oversight of this State agency. It is essentially a hands-off operation. I think they came in only because, I suspect—I don't know why they came in—but because it involved a number of States. If it involved a single State I suspect it would have been left to the State to have worked it out, which I think would have been proper.

I don't fault Social Security because they did what they did, nor do I fault their timing. As many States as were involved, I think it was appropriate for them to do what they did.

Mr. **Rangel**. I have no further questions.

Mr. **Pickle**. Mr. Lowe, I want to ask you some questions. I understand there has been no increase in the fees for medical examinations in Pennsylvania since 1974?

Mr. **Lowe**. That is correct, Mr. Chairman.

Mr. **Pickle**. Does this pose a problem for you in getting adequate examinations?

Mr. **Lowe**. It is one of the problems we have. We are in the process now of reviewing that fee schedule.

Mr. **Pickle**. Is that one reason why you have used volume providers such as Johnson & Byers?

Mr. **Lowe**. That is part of it.

Mr. **Pickle**. How many doctors work for Johnson & Byers?

Mr. **Lowe**. I think there are six.

Mr. **Pickle**. Who interprets the X-rays for Johnson & Byers, do you know?

Mr. **Lowe**. There is a radiologist who interprets them and he is stationed in Florida.

Mr. **Pickle**. Based in Florida?

Mr. **Lowe**. Based in Florida, yes.

Mr. **Pickle**. Is that unusual?

Mr. **Lowe**. It is, but the way Johnson & Byers operates in Pennsylvania is they have a van with X-ray equipment in it. Chest X-rays are taken there and shipped to Florida for interpretation. That interpretation is sent back to Johnson & Byers.

Mr. **Pickle**. They use a van?

Mr. **Lowe**. They use a van, because they have a number of offices around the western part of the State where they would not want to replicate X-ray equipment.

Mr. **Pickle**. For my information, who is the van registered with, whose name, do you know?

Mr. **Lowe**. Internal Medicine Associates.

Mr. **Pickle**. Who is it? Will you furnish the committee the name?

Mr. **Lowe**. I don't have that information apparently. I will furnish the committee with that information at a later time.

Mr. **Pickle**. More specifically, is the van registered to a Dr. Lipman?

Mr. **Lowe**. Not to my knowledge.

Mr. **Bailey**. Would the chairman yield? The information we had gotten was that the van was registered to that group. That group, that Internal Medicine or whatever it is, this thing in Florida, was an address used by Dr. Lipman, who was the individual mentioned earlier who had the indictment problem.

Mr. **Pickle**. It is in the staff report we have. I think maybe we ought to point it out publicly here, because it is on page 10. Staff believes from its investigation that there is a connection between Johnson & Byers and Dr. Lipman, and have transmitted this information to the Social Security Administration. The Chevy step-van used in the Pittsburgh area had Florida license plates, which were registered to Internal Medical Associates, Perrine, Fla., an address used in the past by Dr. Lipman.

Also, we have been informed by State agency personnel that Dr. Lipman is currently doing lab work for Johnson & Byers and that both doctors previously worked for Dr. Lipman and took over his operation in the Midwest.

Mr. **Lowe**. I have no knowledge of that, but I will look into it, Mr. Chairman.

Mr. PICKLE. The fact that that might have happened doesn't mean that there is an abuse or——

Mr. LOWE. I understand.

Mr. PICKLE. Or malpractice or inadequate administration on the face of it, but there is that connection, and it ought to be pointed out.

Now, let me go on with you. Do you know who does the word processing operation for Johnson & Byers, and where it is processed; is that also in Florida?

Mr. LOWE. Word processing?

Mr. PICKLE. Yes.

Mr. LOWE. I am told it is done in Michigan, Mr. Chairman.

Mr. PICKLE. Michigan. All right, here we have a mobile step van moving around Pennsylvania, word processing done in Michigan, and X-rays read in Florida. Do you send any work down to Texas?

Mr. LOWE. Not yet.

Mr. BAILEY. We understand, Mr. Chairman, that the brains of the outfit are in Texas.

Mr. PICKLE. Well, Mr. Lowe, we understand that Johnson and Byers have cut back recently on the number of examinations they have been doing in Pennsylvania. Is this true and do you know the reason for it?

Mr. LOWE. Yes, it is true. They have cut back, I think the figure now is about 40 examinations a day.

Mr. PICKLE. Forty. Compared to what?

Mr. LOWE. A high of 65 examinations in a day in July, which I have to say to you in all candor I think is outrageous.

Mr. PICKLE. Let's see if I understand you again. In one day in July they made some 65 examinations?

Mr. LOWE. That is correct.

Mr. PICKLE. In that van. Did the van stay in one place? It must have moved at a high speed in a lot of different cities. Do you know did it stay in one place or——

Mr. LOWE. I think those examinations were all performed at a single site.

Mr. PICKLE. They performed some 65. So they have reformed and are now only doing 40 a day?

Mr. LOWE. Forty.

Mr. PICKLE. I am going to ask you if you think the physicians in Johnson and Byers are operating within their areas of medical specialty?

Mr. LOWE. Do I think they are operating in their areas of medical specialty? Yes, I do.

Mr. PICKLE. But you think the number of examinations they are turning out is outrageous, is that your phrase?

Mr. LOWE. That is my phrase, yes. That is why we want to develop a standard. Someone asked a while ago what help the States could use from the Federal Government. One of the things, it seems to me, that would be helpful is some agreement on what a reasonable standard is for how many examinations per day per hour. We are working on that now. But I think we need to sidle up to that issue.

Mr. PICKLE. I think that is an appropriate observation. It is very difficult to set such a standard.

Mr. LOWE. I am speaking about reasonableness. Reasonableness.

Mr. PICKLE. Yes. Well, I think we would agree on that, too. In the case of the Thurman and Thurman examinations, the physician in Tennessee estimated he did 25, 35 cases a day. Now, that is lower than the Johnson and Byers operation. Somewhere between 65 and 25, or even lower, is where you are trying to establish what is reasonable?

Mr. LOWE. I think we would try to establish what is reasonable within the kind of examination that is going to be conducted. If it is psychiatric, whether it is cardiac pulmonary or arthopedic.

Mr. PICKLE. If Johnson and Byers got into their van and they went to this particular location and made 65 examinations, how did they get the word out to that many people, where does the notice come from?

Mr. LOWE. It came from us unfortunately.

Mr. PICKLE. In what way? How did they all come in for examinations?

Mr. LOWE. We schedule examinations through our regional office in Greensburg.

Mr. PICKLE. Did you set that many for him to examine?

Mr. LOWE. We apparently did, yes.

Mr. PICKLE. Why did you do that?

Mr. LOWE. I don't know, but I am going to find out.

Mr. PICKLE. Who ordered you to do that? How could you say on the one hand it is outrageous, yet you sent them there for the examinations?

Mr. LOWE. Because, Mr. Chairman, I am just getting on top of the DDD operation in Pennsylvania.

Mr. BAILEY. Would the gentleman yield?

Mr. PICKLE. I yield to Mr. Bailey.

Mr. BAILEY. While the Chairman was not here, I had asked some questions concerning investigations by the State agency. It is my understanding that much of the information concerning these guidelines had not been communicated to you by Social Security. Is that correct?

Mr. LOWE. That is correct.

Mr. BAILEY. When did you begin to look into these problems and when did you first learn it?

Mr. LOWE. I first learned of it from a letter I got from a claimant who went through the experience of an examination with the van. I responded to that. I was absolutely horrified by some of the information in that letter. Simultaneously, I became aware of some of the problems from a reporter, from the media in Pittsburgh.

Mr. BAILEY. And have begun an investigation?

Mr. LOWE. And have begun an investigation.

Mr. BAILEY. I thank you, Mr. Chairman.

Mr. PICKLE. Mr. Lowe, if you sent to Johnson and Byers a large number of people to be examined, I assume you did it because of the workload in your State?

Mr. LOWE. Yes.

Mr. PICKLE. And I assume you did it because you have been directed by Baltimore to process a certain number of cases?

Mr. LOWE. We walk a tightrope. The tightrope goes something like this. On the one hand, we have high volume, 150,000 cases a year. We have a quick turnaround requirement, goals to be met by SSA that we are given.

On the other side of that tightrope is how do you treat clients as human beings? One must strike a balance in that. That is what we are attempting to do now. There will not be any more scheduling of 65 examinations a day. We are taking a look at the issue of 40 examinations a day.

Mr. PICKLE. Why did the SSA this past year ask you to make that many examinations in effect by saying you had to process so many cases? Why was that ordered?

Mr. LOWE. Let me ask the question here of my colleague.

I am told by Mr. DelPaine that we scheduled that many examinations because of the workload we had. We were not told to schedule that number of examinations by SSA. Apparently what happens is that as we have new cases coming into examination for eligibility, at the same time, we are reexamining a third of the cases that were already on the rolls. At that time in July, it must have been a peak time in terms of how many people we had to look at.

Mr. PICKLE. Mr. Crank had indicated that the workload had gone up tremendously this year. I was concerned at first, as I asked earlier question, if this was because we had ordered you to make the periodic reviews, but those reviews are not to go into effect now until January. Apparently this year the Administration has said in addition, they are going to ask for certain reviews on disabilities. I presume to try to clear up a lot of cases where they believe people are not eligible, that they will be taken off rolls and there will be a saving?

Mr. LOWE. Yes.

Mr. PICKLE. Is that a reasonable assumption why the SSA has asked for these reviews? Would either of you comment? Is that reasonable? So the workload has gone up and because they are trying to clear up a lot of cases as quickly as possible. If they can be cleared up there would be a savings. Is that probably what has happened?

Mr. LOWE. I believe that is what happened.

Mr. PICKLE. Mr. Brown?

Mr. BROWN. Yes, sir. I believe this was a result of the General Accounting Office finding of about half a million ineligible beneficiaries on the rolls. And if they were removed this year it would save about $2 billion.

Mr. PICKLE. Do either of you disagree with the General Accounting Office finding?

Mr. BROWN. It might be an underestimate. We are terminating roughly 47 percent of those cases.

Mr. PICKLE. Why has such a big backlog been created in the past?

Mr. BROWN. These are people who have been on the rolls for years and never had their cases reexamined by a State agency. Criteria has subsequently changed and they no longer meet the requirements.

Mr. PICKLE. I can see why the Administration, SSA, would want to clear up these cases. I can understand why you would have a heavier load, perhaps this year than in the past. You can also anticipate the load is going to increase because of not only the attempt to clear up cases now but because of the reviews that are going to be necessitated in the future?

Mr. LOWE. That is correct.

Mr. PICKLE. So we have got to appropriate these funds for consultative examinations and there is a need for accessability for quality examinations from private sources or volume providers. We are going to be appropriating a lot of money if we are going to be certain that these cases are finalized as quickly as possible. So the expenses probably will get higher as the volume increases.

It would seem to me then that we, protecting our trust fund money, have got to be certain that we do it as quickly as possible with as much quality assurance as possible, or else we have got to change the scheduling or the way we handle them. So I would say to both of you, representing the State agencies which have been spotlighted on this issue, that other States are going to be having the same difficult problems, and we will be talking to them as we have to you. We will be having testimony later from the individual providers that we are concerned about right now.

So I will conclude the hearing for now and say we can probably expect another hearing by either the Social Security Subcommittee or the oversight committee, or jointly, whether it will be in 30 days or soon thereafter.

I would like Mr. Crank to know again that we will resume this line of inquiry because it is a serious question and we must have some better understanding of what should be our standard goals.

Does either of you have an additional statement?

Mr. BROWN. Mr. Chairman, you mentioned processing time. I think we badly need some relief in terms of the expectation Social Security is going to have on processing time. As you know, the regulations provide for target goals and thresholds. We are 4 or 5 days below the threshold and probably before fall is out, our processing time will be so high we will not be meeting the required level. We cannot possibly do that, so I think the Administration must look at the position State agencies find themselves in and say we can no longer expect that kind of processing time.

I think Congress must take a different approach to it. With regard to the Federal criteria for examinations, that may or may not work unless there is a level of payment commensurate with that criteria. I think there has to be comparability on the time the physician spends with the patient and how much you are going to pay him for it.

The third thing—and I am hesitant, Mr. Bailey, to answer the question you asked earlier, I may regret it—but with regard to the 100 cases we evaluated on the Thurmans, we sent out the surveys to 100 patients. Eighty two and a half percent of those were denied, compared to an average of about 73 percent across the board for us. So in that group it was slightly higher than our average rate. That is not surprising.

Mr. PICKLE. Let me ask Mr. Lowe, in this hot day in July that you had these 65 cases—was it 65?

Mr. LOWE. Sixty-five.

Mr. PICKLE. Sixty-five cases. How many of those were approved as for continuing disability?

Mr. **Lowe**. Now, remember that the physicians do not approve or deny. They only confirm a condition, an impairment.

Mr. **Pickle**. All right.

Mr. **Lowe**. I don't know. I can find that out for you.

Mr. **Pickle**. Yes, I would like to know. I think we have asked for some of that information but have not gotten it yet, if I am correct. If they had 65 examinations, how often did they say yes, that is that their disability continued. We want to know what was their judgment on it.

Mr. **Lowe**. We will find that out for you.

Mr. **Pickle**. Please submit that.

[The following letter was subsequently received:]

Bureau of Vocational Rehabilitation,
Harrisburg, Pa., October 13, 1981.

Hon. J. J. Pickle,
Chairman, Social Security Subcommittee, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Chairman Pickle: Enclosed is information intended to clarify and provide answers to issues and questions brought to our attention as a result of the recent Hearings of your Subcommittee on volume C/E providers.

(1) When did Pennsylvania Disability Determination Division respond to Social Security's teletype regarding volume C/E providers?

Our response was sent via teletype on July 30, 1981—the due date on Social Security's request.

(2) Would we provide a copy of the Fee Schedule we use and indicate when it was revised?

The requested Fee Schedule is attached and our records indicate a revision date of 1975.

(3) How many of the sixty-five (65) claimants examined on July 8, 1981 by the Johnson and Byers group had their disability claims allowed or denied?

14 claims were allowed or benefits continued. 48 claims were denied or benefits ceased. 3 claims are still pending in the Agency.

In addition to these questions, other questions were posed regarding Drs. Johnson and Byers for resolution.

(4) Is there any involvement in the Pennsylvania Disability Determination Division with Dr. Richard Lipman?

The Pennsylvania State Agency has not had any direct relationship with Dr. Lipman. However, Drs. Johnson and Byers are associated with Dr. Lipman in the following manner.

In 1977, Dr. Neil Johnson responded to an article in the New England Journal of Medicine to perform examinations for Internal Medicine Associates of Grand Rapids, Michigan. Since then, Drs. Johnson and Byers have developed their own operation of conducting consultative examinations. Dr. Richard Lipman does currently serve in an administrative position with Internal Medicine Associates in Florida.

Drs. Johnson and Byers do lease the van which houses the X-ray and laboratory supplies from Internal Medicine Associates. They also utilize Internal Medicine Associates to perform their transcription services and X-ray interpretations. Dr. Allen Fishman, Radiologist, an associate of Internal Medicine Associates, does the X-ray interpretations.

Dr. Neil Johnson emphasized the fact that they do not work for Internal Medicine Associates but that Internal Medicine Associates provides a service to them.

(5) Who is "Internal Medicine Associates"?

The main office is located at 9500 S.W. 175th Terrace in Miami, Florida. There is also an office located in Grand Rapids, Michigan that currently performs examinations for the Michigan State Agency. The following is a list of physicians who are associated with this firm: Richard Lipman. M.D.; William Escoffery, M.D.; Timothy Grant, M.D.; Allen Fishman, M.D.; John McAdory, M.D.; Ralph Geiger, M.D.; and William Cummings, M.D.

(6) Is Dr. Lipman associated with Internal Medicine Associates?

Dr. Richard Lipman had in the past performed consultative examinations, but in questioning Drs. Johnson and Byers regarding Dr. Lipman's present activities with Internal Medicine Associates, they stated that Lipman serves in an administrative position only.

(7) Does Dr. Richard Lipman perform laboratory work for Drs. Johnson and Byers?

Laboratory work (blood and urinalysis) collected by Drs. Johnson and Byers for our Disability Determination Program had been sent to Internal Medicine Associates for routing to one of the two independent laboratories. The laboratories that performed the analysis were: Metpath, Inc., 2890 Griffin Road, Fort Lauderdale, Florida; Metpath, Inc., 800 Corporate Circle, Harrisburg, Pennsylvania; and National Health Laboratories, One N.E. 19th Street, Miami, Florida.

Since September 21, 1981 laboratory analysis is performed by: Medcheck, Inc., 1386 Old Freeport Road, Pittsburgh, Pennsylvania.

The van that houses the laboratory equipment used by Drs. Johnson and Byers is leased from Internal Medicine Associates and is registered under Drs. Lipman and Escoffery.

I hope this information will be helpful to the Committee.

Sincerely,

GEORGE LOWE, *Director.*

DISABILITY DETERMINATION DIVISION—BUREAU OF VOCATIONAL REHABILITATION—PROFESSIONAL SERVICE FEE SCHEDULE, APR. 1, 1975

Service code	Service description	Maximum fee
42-61010	Ophthalmologic examination (revised June 1981)	$35.00
42-61020	Dermatologic examination	35.00
42-61030	Gynecologic examination	35.00
42-61040	Internal medicine examination	35.00
42-61050	Neurologic examination	35.00
42-61070	Ophthalmologic—refraction (visual analysis)	12.50
42-61080	Ophthalmologic medical examination of eyes	12.50
42-61090	Ophthalmologic—refraction with medical examination (eyes)	25.00
42-61100	Orthopedic examination	35.00
42-61110	Otorhinolaryngologic examination	35.00
42-61120	Otologic examination	35.00
58-64921	Audiologic examination including air and bone conduction, and speech discrimination	20.00
42-61130	Physiatric examination	35.00
42-61140	Plastic surgical examination	35.00
42-61150	Psychiatric examination	35.00
42-61180	Surgical examination	35.00
42-61190	Urologic examination	35.00
44-62060	Hospital abstract note (1)	5.00
42-61221	Medical evidence from physician's records	8.00
42-61000	General medical examination	10.00
42-61125	Pediatric specialty examination	35.00
42-61161	Uncancelled, broken appointment for specialty exam note (2)	½ Fee
42-61171	Followup specialty consultative examination with report	15.00
42-61200	Home examination additional fee	2.50
None	Unlisted diagnostic and severity testing note (3)	
47-62745	Individual diagnostic intellectual evaluation plus organic disorders note (4)	40.00
47-62840	Comprehensive diagnostic psychological examination includes individual intellectual, projective and graphic tests.	80.00
47-62730	Individual vocational battery (name of test)	7.00
47-62820	Individual diagnostic personality evaluation with graphics note (5)	20.00
47-62850	Psychological reports from psychologist's records	8.00
50-87510	SMA-6	7.50
50-87520	SMA-12	10.00

LABORATORY

Fees paid for laboratory procedures performed by hospitals, rehabilitation centers, or private physician shall be those fees paid which are normally charged private patients for the same service or services. (Rehabilitation Services Section No. 7, dated March 31, 1967).

Mr. PICKLE. Mr. Bailey, do you have another question?

Mr. **Bailey**. Yes, just two final questions, Mr. Chairman, and a comment. Mr. Lowe, would you provide for me and for the respective subcommittees here a list of fee schedules. If you would look at Mr. Brown's testimony, you will find an attached group of fee schedules for respective services. In Pennsylvania, I believe—I maybe mistaken—they have not been revised since 1974, is that correct?

Mr. **Lowe**. I think that is right, yes.

Mr. **Bailey**. I am not sure. I would be grateful for that information.

Mr. **Lowe**. I would be glad to provide that. You should know that fee schedule is presently undergoing review by us now and we are probably going to recommend an increase. But I will be happy to share the fee schedule with you.

[See letter at p. 93.]

Mr. **Bailey**. Mr. Brown, the Chairman had to leave and I will conclude the hearings in just a moment here so hang on tight. According to my arithmetic, the cheapest fee schedule for service that you have, I don't know exactly what it was, but if memory serves me correctly, it was $17.80 for some particular item. Sixty examinations a day would run over a $1,000 a day.

My question of you is, have either of you ever looked at the practices or procedures of this consultative examination process? When they were doing these, did they run 30 a day for how many days, or was there an average? Do you know from the experience you had down there?

Second, if they did, is there some information you could provide on their overhead? Earlier here we were talking about physicians assistants. Are there tests which are conducted and you are billed for? Were you overbilled for tests perhaps that were not requested? How thorough was your investigation?

Mr. **Brown**. Overbilled for tests not requested? No, the opposite was true. They provided services that we did not pay for that in their opinion were needed. A substantial amount. The $17.80 is not for an examination.

Mr. **Bailey**. Wait, 60 examinations a day and they overtested those people, but didn't charge for it, is that what you are saying?

Mr. **Brown**. Yes, I am saying in some instance they may have taken a chest X-ray. It may have been a Saturday when they couldn't reach us for payment authorization.

Mr. **Bailey**. How do you know those tests took place? Do you have any way of verifying it? This word processing thing intrigues me. The allegation had been made that some of these reports were voluminous, they were exaggerated, that they came out with a beautiful report on an individual but spent 2½ minutes or 3 minutes with him.

Mr. **Brown**. The time keeps getting shorter. We will have minute examinations probably before long. I am aware of those allegations. But bear in mind the 30 or 35, whatever the number, particularly in Tennessee, are not that number of physical examinations. These include applicants that would be sent in for a pulmonary function test. The physician may not have seen them at all. It may be for a repeated electrocardiogram or additional lab work. These are the number of people scheduled during a day, not necessarily for examinations.

Mr. **Bailey**. Have you ever audited these? Do you send an investigator out to check on them?

Mr. **Brown**. Yes, we have had an employee visit on site unannounced.

Mr. **Bailey**. Staff informs me that that magic figure of 35 is a combination of Tennessee and Virginia. You mentioned 100 examinations. One of you two mentioned it.

Mr. **Lowe**. I said 65 a day.

Mr. **Bailey**. Sixty-five.

Mr. **Lowe**. In Pennsylvania, incidentally, we do monitor on a sample basis the kinds of examinations that are given.

Mr. **Bailey**. How do you monitor, randomly?

Mr. **Lowe**. Randomly.

Mr. **Bailey**. Individuals, a case basis or on the basis of individuals consultative examinations providers?

Mr. **Lowe**. We have begun to monitor, I don't know the exact method, some of the cases that Johnson and Byers examined, some of the claimants that they have examined, their case files.

Mr. **Bailey**. One last question. Mr. Brown, you know these fee schedules and costs. Did the Social Security Administration have you supply the information that they requested of you in this request for information that the Office of Operational Policy and Procedure apparently sent a request to—I think you were here, I saw you back there when I read that piece of paper—with a reply date of August 3? Did you supply information to Social Security upon request?

Mr. **Brown**. July 29. There was some problem in transmission. I am not sure when they got it. We put it in overnight mail and they got it about the middle of the next week, but yes.

Mr. **Bailey**. They acknowledge receiving the information?

Mr. **Brown**. Yes.

Mr. **Bailey**. It was within a week of when you sent it. In other words, if we said August 10, they got it before August 14, you are telling me?

Mr. **Brown**. In fact, we also gave it to them by phone.

Mr. **Bailey**. Relayed it to them by telephone?

Mr. **Brown**. Yes.

Mr. **Bailey**. Mr. Lowe, do you know when you gave them that information, do you have a date on that?

Mr. **Lowe**. I can get you one. All I can say is that it was prior to the deadline. I don't have a specific date.

Mr. **Bailey**. To follow up on a number of questions—find that for me, would you, when that was communicated?

Mr. **Lowe**. Surely.

[See letter at p. 93.]

Mr. **Bailey**. On the specific questions the chairman and myself were asking about the disallowal approval rates, would you both get that information for us? As to the volume providers, apparently there is a tough definition. I understand, I very much appreciate that. But on at least what your definition is, would you supply a definition for us? And do you consider that a significant difference, significant percentage difference—82 versus 73 disavowal rate?

Mr. **Brown**. I don't, but if you ask me what I compare it with, I don't have anything to compare it with. We will have it but this is going to be very labor intensive doing it. We will have to do it by hand and we have already got more work than we can do.

[The information follows:]

State of Tennessee,
Disability Determination Section,
Nashville, Tenn., November 2, 1981.

John J. Salmon,
Chief Counsel, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

Dear Mr. Salmon: During my testimony before the Joint Committees on September 18, Chairman Pickle and Congressman Bailey requested certain information regarding allowance/denial rates of Social Security Clients undergoing different types of consultative examinations by different types of providers. The attached information is submitted in response to their request.

Sincerely,

Herbert L. Brown, *Director.*

Special Study of Cases Involving Consultative Examinations, Selected Sources

INTRODUCTION

The House Subcommittee on Social Security, Committee on Ways and Means, recently began hearings on the consultative examination (CE) process. The Tennessee DDS Director was asked to testify in September, 1981. He noted results of a limited study of cases including CE's purchased from only one source, a high volume provider of internal medicine examinations. One of the Subcommittee members requested that a similar study be made involving other high volume examiners used in Tennessee. The primary purpose of the study will be to compare allowance/denial rates among various "high volume" sources for consultative examinations.

METHOD

For meaningful comparison, the following populations were sampled:

(1) Cases involving CE's scheduled with high volume sources.

(2) Cases involving CE's scheduled with lower volume sources.

(3) Cases involving CE's of any type, scheduled with any CE source other than one of the "top six" volume providers.

(4) Cases adjudicated on Medical Evidence of Record (MER) only, not involving a CE.

In late July, 1981, the Social Security Administration asked this agency to identify the "top ten" volume providers according to dollar amounts paid. For purposes of this study, it was felt that six of the ten for fiscal year 1981 would be a reasonable number of sources for meaningful comparison. More than six would have required an inordinate amount of work hours for a limited staff, given the necessity to perform the study manually within the proposed time frame. The six sources who were paid at least $45,000.00 in the first ten months of fiscal year 1981 were selected. In rank order, these amounts were as follows:

High volume source:	
A	$599,300.32
B	96,304.73
C	58,437.28
D	46,572.45
E	46,461.64
F	62,615.92

Sources A through E are specialists in internal medicine; source F provides psychological evaluations. It should be noted that source A is a firm employing several physicians, technicians, clerical and other support personnel, and was operating until recently in four cities in Tennessee.

To select six "lower volume" sources for comparison, the "top twenty" first were identified for fiscal year 1981, based on dollar amounts paid through the same time frame indicated above. Payments to this group ranged downward from the amounts listed above for the top six, to a low of $16,944.46 for source number 20. These top twenty names were then set aside, and selection of the six lower volume sources for study purposes was made from the remaining specialists in internal medicine and psychology. Selection was made by random sampling. Five internists and one source for psychological evaluations were thus selected for the lower volume group.

Computer-generated accounting printouts were requested on each of the study vendors. The printouts listed the Social Security numbers, along with financial data, for the time frame specified. In the case of the higher volume vendors, the three-month period between July 1 and September 30, 1981, generated an adequate sample for each source. However, in the case of the lower volume vendors, a six-month period was necessary to generate an adequate sample, from April 1, 1981, through September 30, 1981.

A randomly selected sample of 160 cases for each population was obtained.

(2) The average allowance rate on cases involving CE's by the five higher volume sources for internal medicine examinations was 27.4 percent, compared to a 24.4 percent average for cases involving CE's by the five lower volume internist sources. The three percentage points difference probably is not statistically significant. In other words, based on this study, the probability of an initial claim being allowed if a CE from an internist was involved was no greater, whether the CE was performed by a "high volume" or by a "low volume" provider. If any significant difference existed, it would appear the probability of allowance would be slightly higher with the high volume group.

(3) The allowance rate on cases involving CE's by the highest volume provider, source A, was the highest among the five higher volume sources. Considering only the higher volume group, if in fact the percentage differences between the allowance rates are statistically significant, the probability of an initial claim being allowed would appear higher if the CE were obtained from the highest volume provider.

(4) The range of allowance rates among the five higher volume internist sources was from 13.9 percent to 33.3 percent, a range of 19.4 percent. The range among the lower volume internists was from 17.0 percent to 35.6 percent, a range of 18.6 percent. These data appear relatively comparable.

(5) Cases involving CE's with a source for psychological evaluation have a higher probability of being allowed, based on Table I data. Caution should be observed in interpreting these data too simplistically. Many claims involving a psychological CE also involve other types of CE's, such as internist, orthopedic, ophthalmologic, and the like. This study was not designed to identify the specific Regulation-Basis codes for either allowed or denied claims, nor to identify the primary body system affected in allowed claims. It well may be that many claims involving a psychological CE in fact allowed on other grounds, or on a combination of both psychological and other impairments.

Table II contains the data on reconsideration and Continuing Disability Investigation (CDI) claims sampled in the study. Since the numbers of reconsideration and CDI claims were much smaller compared to the numbers of initial claims, any conclusion drawn on these two types of claims should be quite tentative. A total of 56 reconsideration claims involved CE's from the five high volume internist sources. A total of 68 reconsideration claims involved CE's from the five lower volume internist sources. Generally, the allowance/denial rates for the summary data appear consistent with overall program experience for reconsideration cases. Likewise, the data on CDI claims appears generally consistent with program experience with that type of claim.

Table III gives the breakout information, among CDI claims, for the group of Accelerated/Profile CDI's sampled in the study. Again, caution should be used in interpreting these data, since a larger sample would be preferable. The summary data, containing the average allowance/denial rates for the five high and the five low volume internist sources appear to indicate about equal probabilities of a claimant currently receiving benefits being found eligible to continue to receive such benefits. Again, the continuance rate involving psychological CE's showed a higher probability of continuance, based on a small sample.

SUMMARY

Data obtained in this study did not appear to establish any significant difference in the probability of allowance of a claim for Social Security disability benefits, if an internist or psychological consultative examination was needed and if the examination was obtained from either a "high volume" or from a "low volume" provider.

Caution should be observed in interpreting these data, particularly with respect to denied claims. The program provides for many categories of denial, and some of the sample cases were denied on such bases as "Failure to submit to (another) consultative examination", "Withdrawal of claim (after the study CE was kept)", and the like. In such cases, the study CE report was not a significant factor in the denial, and possibly was not even received or considered, although the denial decision was associated with that particular provider. Possibly, such factors operated fairly equally among the various populations sampled.

Adjudicating SSA disability claims is a complex process. Evidence from treating sources is developed and considered. In about 40 percent of initial claims, some type of consultative examination is purchased. Unsupported opinion evidence from either treating or consulting sources cannot be considered. Consideration can be given only to objective signs, symptoms, and laboratory findings; to functional limitations imposed by impairments; and in some cases, to vocational factors. Consultative sources do not participate directly in the claims decision. Professional lay disability claims examiners, as well as DDS agency review physicians, analyze the medical evidence, and the adjudication of a claim represents a joint decision, often made after extensive claims development from various sources. DDS agency review physicians frequently must modify estimates of remaining physical capacity according to program regulations. The interaction of various factors in claims adjudication, including possible effects on or of consultative examination reports, was not addressed by this study.

TABLE I.—ALLOWANCE/DENIAL RATES, INITIAL CLAIMS ONLY

Population	Number—		Percent—	
	Allowed	Denied	Allowed	Denied
Cases adjudicated on MER only	24	48	33.3	66.7
Cases with CE, any type, any source [1]	26	67	28.0	72.0
Cases with CE, high volume source A	39	78	33.3	66.7
Cases with CE, higher volume source B	34	84	28.8	71.2
Cases with CE, higher volume source C	29	68	29.9	70.1
Cases with CE, higher volume source D	15	93	13.9	86.1
Cases with CE, higher volume source E	35	80	30.4	69.6
Summary data, 5 higher volume sources	152	403	27.4	72.6
Cases with CE, lower volume source U	12	44	21.4	78.6
Cases with CE, lower volume source V	31	56	35.6	64.4
Cases with CE, lower volume source W	24	71	25.3	74.7
Cases with CE, lower volume source X	9	44	17.0	83.0
Cases with CE, lower volume source Y	18	77	18.9	81.1
Summary data, 5 lower volume sources	94	292	24.4	75.6
Cases with CE, higher volume source F (psychological evaluations)	57	54	51.4	48.6
Cases with CE, lower volume source Z (psychological evaluations)	49	53	48.0	52.0

[1] Excluding top 6 higher volume vendors, fiscal year 1981.

TABLE II.—ALLOWANCE/DENIAL RATES BY TYPE OF CLAIM

Population	Initial		Reconsideration		CDI		Total, all claims	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
MER only:								
Allowed	24	33.3	1	2.2	2	20.0	27	21.1
Denied	48	66.7	45	97.8	8	80.0	101	78.9
CE any type, source: [1]								
Allowed	26	28.0	3	21.4	20	41.7	49	31.6
Denied	67	72.0	11	78.6	28	58.3	106	68.4
Higher volume source A:								
Allowed	39	33.3	1	12.5	12	50.0	52	34.9
Denied	78	66.7	7	87.5	12	50.0	97	65.1
Higher volume source B:								
Allowed	34	28.8	1	45.0	12	48.0	47	31.3
Denied	84	71.2	6	55.0	13	52.0	103	68.7
Higher volume source C:								
Allowed	29	29.9	5	22.7	8	44.4	42	30.7
Denied	68	70.1	17	77.3	10	55.6	95	69.3

TABLE II.—ALLOWANCE/DENIAL RATES BY TYPE OF CLAIM—Continued

Population	Initial		Reconsideration		CDI		Total, all claims	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Higher volume source D:								
Allowed	15	13.9	1	9.1	9	34.6	25	17.2
Denied	93	86.1	10	90.9	17	65.4	120	82.8
Higher volume source E:								
Allowed	35	30.4	1	12.5	8	57.1	44	32.1
Denied	80	69.6	7	87.5	6	42.9	93	67.9
Summary data, 5 higher volume sources:								
Allowed	152	27.4	9	16.1	49	45.8	210	29.2
Denied	403	72.6	47	83.9	58	54.2	508	70.8
Lower volume source U:								
Allowed	12	21.4	8	44.4	13	68.4	33	35.5
Denied	44	78.6	10	55.6	6	31.6	60	64.5
Lower volume source V:								
Allowed	31	35.6	3	17.6	15	45.5	49	35.8
Denied	56	64.4	14	82.4	18	54.5	88	64.2
Lower volume source W:								
Allowed	24	25.3	0	0	0	0	24	23.1
Denied	71	74.7	7	100.0	2	100.0	80	76.9
Lower volume source X:								
Allowed	9	17.0	2	16.7	0	0	11	15.3
Denied	44	83.0	10	83.3	7	100.0	61	84.7
Lower volume source Y:								
Allowed	18	18.9	1	7.1	12	44.4	31	22.8
Denied	77	81.1	13	92.9	15	55.6	105	77.2
Summary data, 5 lower volume sources:								
Allowed	94	24.4	14	20.6	40	45.5	148	27.3
Denied	292	75.6	54	79.4	48	54.5	394	72.7
Higher volume psychological source F:								
Allowed	57	51.4	3	42.9	18	75.0	78	54.9
Denied	54	48.6	4	57.1	6	25.0	64	45.1
Lower volume psychological source Z:								
Allowed	49	48.0	6	50.0	17	53.1	72	49.3
Denied	53	52.0	6	50.0	15	46.9	74	50.7

[1] Excluding top 6 higher volume vendors, fiscal year 1981.

TABLE III.—ALLOWANCE/DENIAL RATES, CDI CLAIMS

Population	Accelerated/Profile CDI's		Other CDI's	
	Number	Percent	Number	Percent
MER only:				
Allowed	0	0	2	33.3
Denied	4	100.0	4	66.7
CE any type, source:[1]				
Allowed	16	39.0	20	41.7
Denied	25	61.0	28	58.3
Higher volume source A:				
Allowed	9	42.9	3	100.0
Denied	12	57.1	0	0
Higher volume source B:				
Allowed	9	45.0	3	60.0
Denied	11	55.0	2	40.0
Higher volume source C:				
Allowed	4	40.0	4	50.0
Denied	6	60.0	4	50.0

TABLE III.—ALLOWANCE/DENIAL RATES, CDI CLAIMS—Continued

Population	Accelerated/Profile CDI's		Other CDI's	
	Number	Percent	Number	Percent
Higher volume source D:				
Allowed	8	47.1	1	11.1
Denied	9	52.9	8	88.9
Higher volume source E:				
Allowed	7	70.0	1	25.0
Denied	3	30.0	3	75.0
Summary data, 5 Higher volume source:				
Allowed	37	47.4	12	41.4
Denied	41	52.6	17	58.6
Lower volume source U:				
Allowed	10	66.7	3	75.0
Denied	5	33.3	1	25.0
Lower volume source V:				
Allowed	10	43.5	5	50.0
Denied	13	56.5	5	50.0
Lower volume source W:				
Allowed	0	0	0	0
Denied	2	100.0	0	0
Lower volume source X:				
Allowed	0	0	0	0
Denied	4	100.0	3	100.0
Lower volume source Y:				
Allowed	8	47.1	4	40.0
Denied	9	52.9	6	60.0
Summary data, 5 Lower volume source:				
Allowed	28	45.9	12	44.4
Denied	33	54.1	15	55.6
Higher volume psychological source F:				
Allowed	9	69.2	9	81.8
Denied	4	30.8	2	18.2
Lower volume psychological source Z:				
Allowed	10	58.8	7	46.7
Denied	7	41.2	8	53.3

[1] Excluding top six higher volume vendors, fiscal year 1981.

Note.—Data on total CDI claims is contained in column 3, table II.

Mr. BAILEY. That is the last part and I am going to finish up and adjourn the hearing. I will only comment that when we had Mr. Stockman and Mr. Schweiker in here, questions were raised about cost-benefit ratios on certain programs. Some specifically dealt with disability, incidentally, one of them on our rehabilitation program where you get people off disability, get them back paying taxes.

We had a cost-benefit relationship on that program of $1.83 returned to the Government saving the taxpayer, saving the disability fund for every dollar we invested in the program. The damn thing was thrown in with block grants, and it is going to suffer. It is a perfectly good example of what happens when you don't study programs on a pragmatic basis, and we end up paying more for services, doing less of a job for people, at least a less fair job when we take this kind of approach to the budget process.

So I will pass your recommendations, gentlemen, as I at least did decipher them, onto the administration on your behalf. I would be very happy to do that.

Any last comments?

Mr. **Lowe**. I have none.

Mr. **Brown**. No sir.

Mr. **Bailey**. Both subcommittees will stand adjourned, but I want to advise both of you gentlemen that both Chairman Pickle and Chairman Rangel, before he left, personally assured me that they are going to have additional hearings, and that we are going to get to the bottom of some of these questions and problems.

Mr. Rangel, in particular, said that he is going to look into it thoroughly, so I would start doing some homework because it is obvious that there are going to be a lot of questions asked.

Thank you very much.

[Whereupon, at 12:30 p.m., the hearing was adjourned.]

○